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FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7227 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07215											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>						c. LENGTH OF STAY in lb <u>2 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dam at R. Paul Smith Power Plant Potomac River</u>						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					
f. STREET ADDRESS <u>1718 Virginia Ave.</u>						g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Lee</u> Last <u>Anderson</u>						4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 61</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 17 1944</u>		9. AGE (In years last birthday) <u>16</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>					
13. FATHER'S NAME <u>Herbert Leo Anderson</u>						14. MOTHER'S MAIDEN NAME <u>Vivian Lorraine Robinson</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>none</u>					
17. INFORMANT <u>Herbert :ep Anderson</u>						17a. Address <u>1718 Va. Avenue Hagerstown Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation due to choking</u> 9299.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <u>Twelve</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming in Potomac River</u>					
20c. TIME OF INJURY Month, Day, Year <u>June 12 1961</u> Hour <u>9:00</u> a.m. p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>						20f. (City or town) (County) (State) <u>Williamsport Wash. Md</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, MD</u>						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						22b. DATE THEREOF <u>June 16-61</u>					
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Memorial Gardens</u>						22d. LOCATION (City, town, or country) (State) <u>Hagerstown Md.</u>					
23. FUNERAL DIRECTOR <u>Albert L. Leaf</u>						24a. REC'D BY REGISTRAR <u>June 15 '61</u>					
24b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>											

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TO BE SIGNED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO BE SIGNED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO BE SIGNED BY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/59

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7228
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07216

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 53 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last FREDERICK ARTHUR ANDREWS		4. DATE OF DEATH Month Day Year JUNE 11 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/1881
9. AGE (In years lost birthday) 79rs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORTICULTURIST		10b. KIND OF BUSINESS OR INDUSTRY FLORIST	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAMS ANDREWS		14. MOTHER'S MAIDEN NAME MARY JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-26-0065	
17. INFORMANT MR. GEORGE W. ANDREWS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic glomerulonephritis and Acute gastroenteritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Absence of ear due to carcinoma		INTERVAL BETWEEN ONSET AND DEATH 5 days indif. 5-30-61	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour: 5 m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-1 1961 to death, that (I) (we) lost the deceased alive on 6-11 1961, and that death occurred 3:25 PM from the causes and on the date stated above.			
22a. SIGNATURE Robert F. Keagle		22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) Robert F. Keagle		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/13/61	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		25. REC'D BY REGISTRAR DATE JUN 14 '61	
25b. REGISTRAR'S SIGNATURE			

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TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be signed in 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7229

07217

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>227 So prospect St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET ANN ANTHONY</u>		4. DATE OF DEATH <u>June 3 1961</u> 19 <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 23 1866</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Cearfoss Wash Co Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Elder Nicholas Martin</u>	
14. MOTHER'S MAIDEN NAME <u>Barbara Ann Neibert</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Miss Chloe Anthony 227 So Prospect St</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X cerebral hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>arteriosclerosis</u> (a), stating the underlying cause last. (c) <u>arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>1 day</u> <u>year</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md.</u>
21. I certify that (I) (this hospital) attended the deceased from <u>5/28</u> <u>1961</u> , to <u>6/3</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>6/2</u> <u>1961</u> , and that death occurred at <u>2A</u> <u>M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>6/3/61</u>		22c. PHYSICIAN'S NAME (Type) <u>H.N. WEEKS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/6/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Dunkard Cemetery</u>		23d. LOCATION (City, town or county) <u>Broadfording Wash Co Md</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7230

07218

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>154 N. Artizan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Vida</u> Middle <u>Blanche</u> Last <u>Arrington</u>			4. DATE OF DEATH Month <u>June</u> Day <u>11</u> Year <u>19 61</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>July 21 1909</u>		9. AGE (In years last birthday) <u>51 yrs.</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>20</u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stroudsburg Pa.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>Charles Wesley Dailey</u>			
14. MOTHER'S MAIDEN NAME <u>Blanche Marion Smith</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215 30 4420</u>				17. INFORMANT Address <u>154 N. Artizan St. Williamsport, Md.</u> <u>James Vaughn Arrington</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure from metastases</u> DUE TO (b) <u>Abdominal carcinomatosis</u> DUE TO (c) <u>Poss. primary carcinoma of pancreas</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		(County) <u> </u>		(State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1961</u> , to <u>June 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 10, 1961</u> , and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John C. Stauffer</u> M.D.				22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. STAUFFER, M.D.</u>				22d. ADDRESS <u>145 S. PROSPECT ST HAGERSTOWN, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Memorial Gardens</u>			
23d. LOCATION (City, town or county) <u>Hagerstown Md.</u>		(State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert A. Leaf Williamsport, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>			
25b. REGISTRAR'S SIGNATURE <u> </u>				25c. REGISTRAR'S SIGNATURE <u> </u>			

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed in 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNITED STATES OF AMERICA

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DATE 01/11/2001

VS. A15ME
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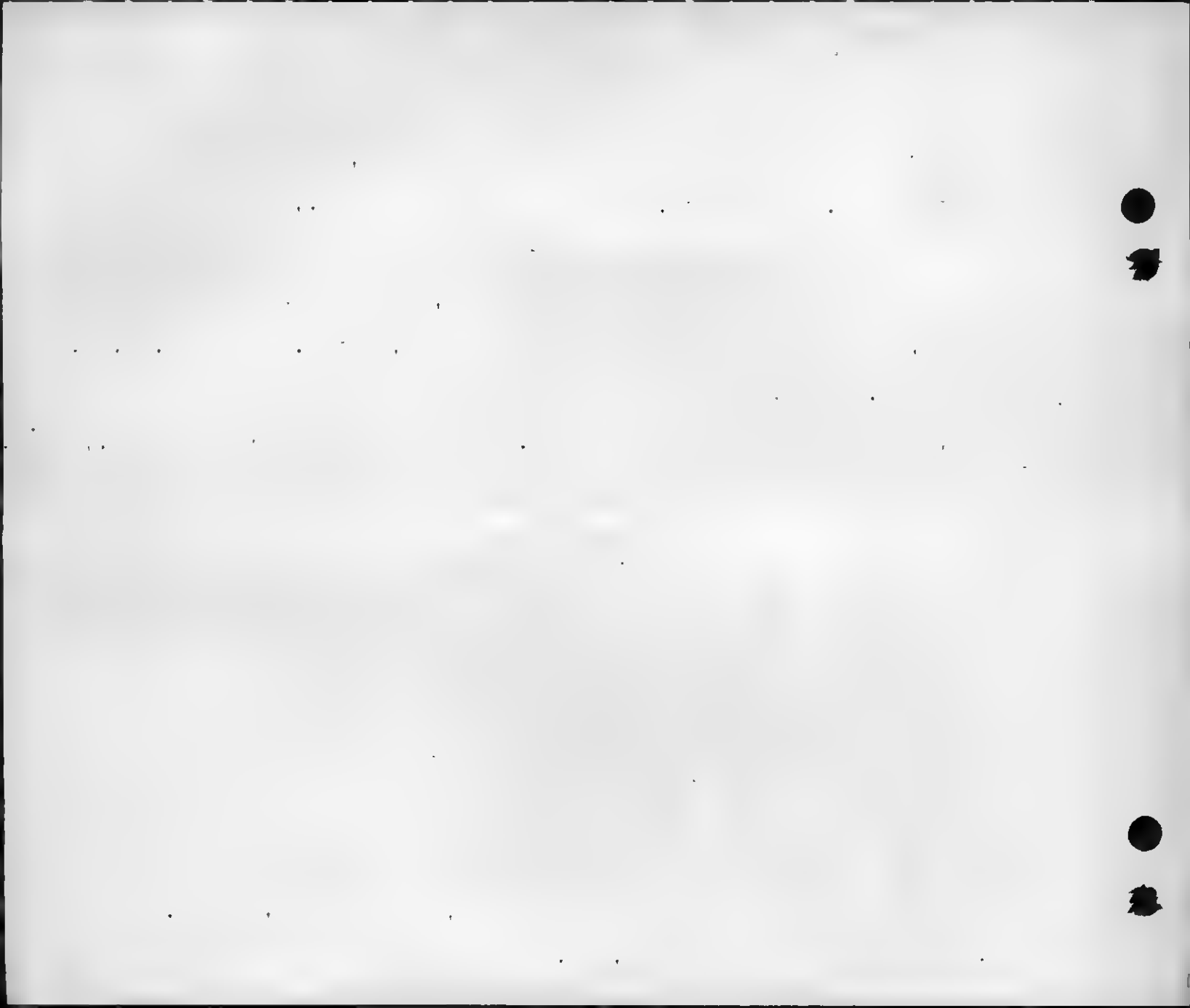
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07220

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hosp.		d. STREET ADDRESS 113 Blaul Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Barbara Ellen BARNES		4. DATE OF DEATH Month 6 Day 24 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1886
9. AGE (In years last birthday) 75 yrs		IF UNDER 1 YEAR: Months 75 Days 24 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook,		10b. KIND OF BUSINESS OR INDUSTRY Restaurant	
11. BIRTHPLACE (State or foreign country) Artemas, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Barnes		14. MOTHER'S MAIDEN NAME Sarah Jane Diehl	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. No.	
17. INFORMANT Mrs. Cora Appold		Address 604 Fairview Ave., Md. Cumb.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix uteri with Metastasis DUE TO (c) Four years		INTERVAL BETWEEN ONSET AND DEATH One week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 24, 1961 to June 24, 1961 , that (I) (we) last saw the deceased alive on June 24, 1961 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE June 24, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave. Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/61	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery,		23d. LOCATION (City, town, or county) (State) Artemas, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR DATE JUN 27 '61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE William L. Farris	

TO BE SIGNED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician.

TO BE SIGNED BY THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

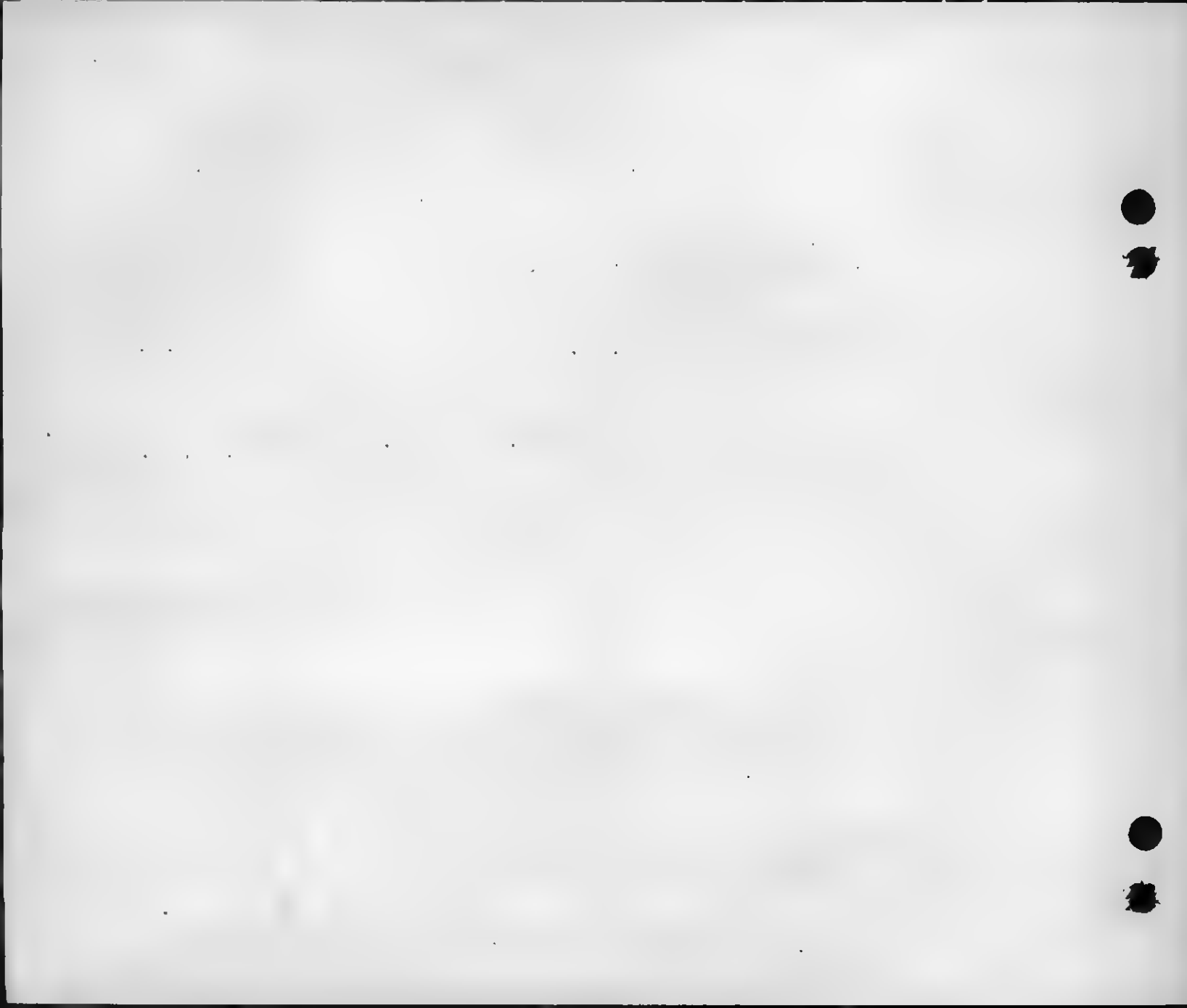


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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1 PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institut on: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 2 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>				e. STREET ADDRESS <u>Rural Williamsport Md RFD #2</u>			
3 NAME OF DECEASED (Type or print) <u>Roy</u> First <u>Leslie</u> Middle <u>BECKLEY</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1961</u>			
5 SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>June 19 1886</u>	9 AGE (In years last birthday) <u>74</u> yrs	IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R. R.</u>		11 BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13 FATHER'S NAME <u>Charles Elmer Beckley</u>				14. MOTHER'S MAIDEN NAME <u>Laura Ardinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717 07 9339</u>		17 INFORMANT <u>Mrs. Mable G. Beckley</u> Address <u>Williamsport Md. R. F. D. #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> <u>177X</u> DUE TO <u>Carcinoma of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>4 years</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>April 19, 1961</u> to <u>June 3, 1961</u> , that (I) was last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>7:35 P. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u>				22b. DATE <u>June 3, 1961</u>		22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>	
22d. ADDRESS <u>1500 Penna. Ave Hagerstown Md</u>				22e. ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7234

07222

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>8 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>517 No Mulberry St</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>517 No Mulberry St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANETTA VIOLET BENNETT</u>		4. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. PLACE OF BIRTH (County & State, or foreign country) <u>Pa. Fayette Co</u>
13. FATHER'S NAME <u>Nathan Divens</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>---</u>	
17. INFORMANT <u>Edgar Bennett</u>		Address <u>517 No Mulberry St Hagerstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0</u> DUE TO <u>Lepatic Coma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>portal Cereberis</u> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 weeks</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year <u>None</u> 19 <u>19</u> Hour a.m. <u>None</u> p.m. <u>None</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town, (County) (State) <u>---</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> <u>1961</u> , to <u>June 5</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>61</u> , and that death occurred at <u>7 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John D. Turco</u>		22b. DATE SIGNED <u>6-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John D. Turco, M.D.</u>		22d. ADDRESS <u>302 N. Potomac St-Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	
25a. REC'D BY REGISTRAR <u>JUN 8 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with how after death. Page 4
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
 ISM 9/59

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

7235

67223

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HELEN First IRENE Middle BICE Last				4. DATE OF DEATH JUNE Month 16 Day 19 Year 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/28/1900	
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) INDIANA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME PHILIP B. HEEFNER				14. MOTHER'S MAIDEN NAME NELLIE V. MAUGANS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO 214-09-0442		17. INFORMANT MRS. LOIS JOAN STEVENS Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Carcinoma of cervix uteri Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____ INTERVAL BETWEEN ONSET AND DEATH 22							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from July 30, 1960 to June 16, 1961 , that (I) (we) last saw the deceased alive on June 16, 1961 , and that death occurred at 494 from the causes and on the date stated above							
22a. SIGNATURE L. L. Packard Jr				M. D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/17/61	
22c. PHYSICIAN'S NAME (Type) L. L. PACKARD JR				22d. ADDRESS			
23a. BURIAL CREMATON, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/19/61		23c. NAME OF CEMETERY OR CREMATORY WOLFESVILLE U.B. CHURCH		23d. LOCATION (City, town, or county) (State) WOLFESVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown				25a. REC'D BY REGISTRAR DATE JUN 20 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL PUBLIC: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07224

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	c. LENGTH OF STAY IN 1b <u>5 weeks</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	<u>X-2</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Washington County Hospital</u>		d. STREET ADDRESS <u>9400 Leesboro Avenue</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Bond</u> Last <u>Bond</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1905</u>
9. AGE (In years last birthday) <u>53</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>		13. FATHER'S NAME <u>Greenburg Smith</u>	
14. MOTHER'S MAIDEN NAME <u>Marjaret Rachel Pratt</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)	
16. SOCIAL SECURITY NO. <u>214-36-4231</u>		17. INFORMANT <u>Blady Hill (daughter)</u> Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolus</u> <u>7.3.3 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pathological fracture of rt. hip</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, hypertension & probable heart disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>11:15</u> 19 <u>61</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>61</u> , to <u>June 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>61</u> , and that death occurred at <u>11:15 A.M.</u> , from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John J. Dalbey</u> M.D.		ADDRESS (Street, city or town, state) <u>115 King St.</u> DATE SIGNED <u>June 6, 1961</u>	
PHYSICIAN'S NAME (Type) <u>John J. Dalbey, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
22b. DATE THEREOF <u>6/10/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	
22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sumner</u> ADDRESS <u>Roe Kettle, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Calvin L. Fries</u>	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7237

CERTIFICATE OF DEATH

Reg. Dist. No.

07225

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W.VA</u> b. COUNTY <u>PRESTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGWOOD</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>R.F.D. #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>BRYAN</u> Middle <u>N.M.N.</u> Last <u>BROADWATER</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3, 1961</u>		9. AGE (In years lost birthday) yrs. <u>3</u> Months <u>3</u> Days <u>30</u>		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <u>JAMES ALBERT BROADWATER</u>				14. MOTHER'S MAIDEN NAME <u>DORIS JEAN COZAD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u> Address <u>KINGWOOD W.VA.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>o. n.</u> Month <u>19</u> Day <u>19</u> Year <u>19</u> p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-3-61</u> , 19 <u>61</u> , to <u>6-3-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-3-61</u> , 19 <u>61</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. D. Dove Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>214 N. Potomac</u>		DATE SIGNED <u>6/9/61</u>	
PHYSICIAN'S NAME (Type) <u>DR. F. D. DOVE JR., HAGERSTOWN, MD.</u>				<u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/9/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hospital Lab</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Wash. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Turner, M.D. Wash County Hosp</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 12 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinn</u>	



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

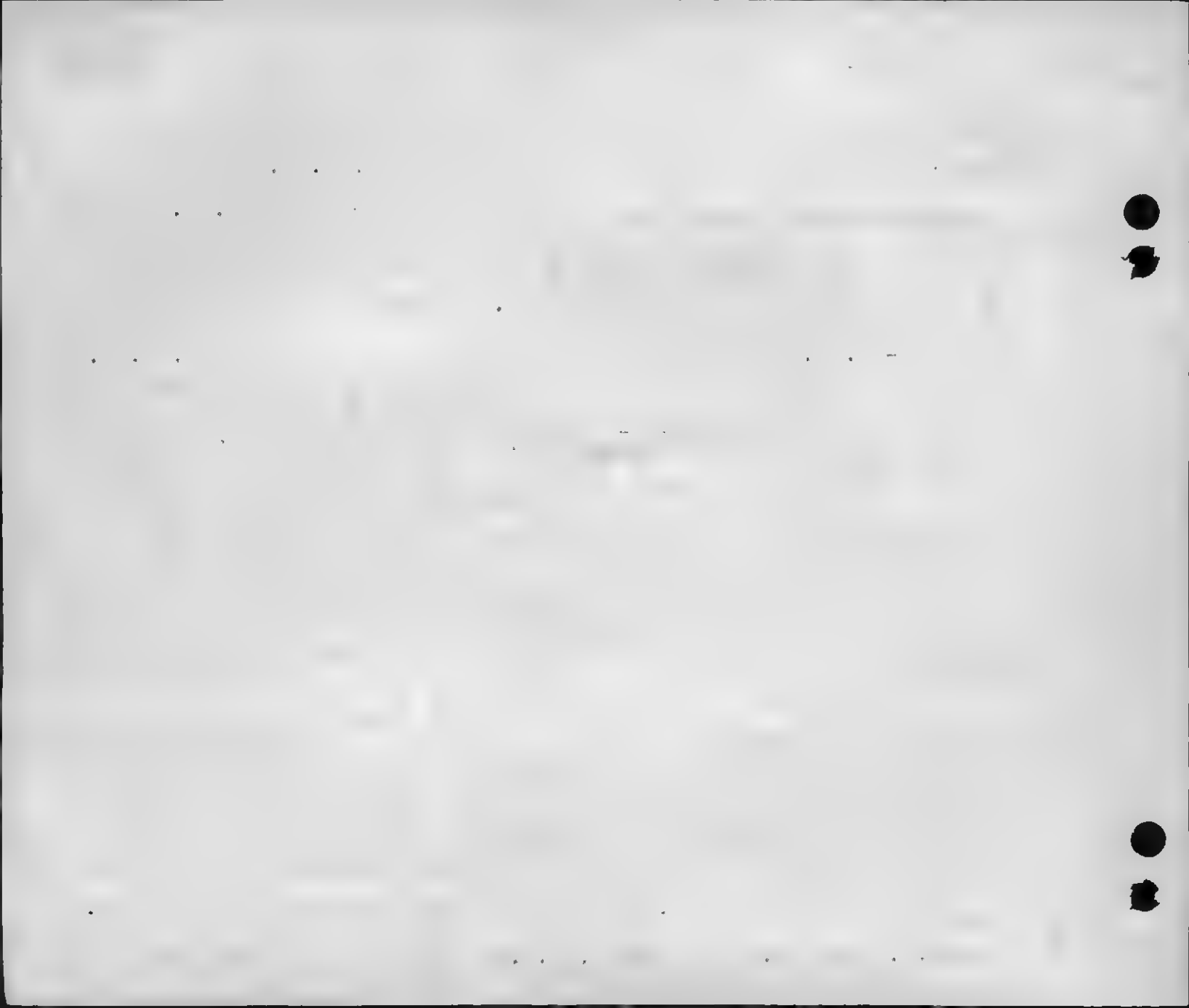
VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7233

07226

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY Washington, D. C. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 3070 Thayer Street N. E. d. STREET ADDRESS 3070 Thayer Street N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dewey Lathrobe Brown	4. DATE OF DEATH Month 6 Day 18 Year 1961	5. SEX male	6. COLOR OR RACE white
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 21, 1898	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U. S. Navy Yard	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Albert Brown	14. MOTHER'S MAIDEN NAME Anna Elizabeth Shaw	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no	16. SOCIAL SECURITY NO. 218-34-7212
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull - + cerebral 8/6X DUE TO Conditions, if any, which gave rise to immediate cause (b) Hemorrhage. (c) Hemorrhage. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), (b), and (c). Thrown from Auto when hit broadside by another car		17. INFORMANT Mrs. Nellie Brown (same as above) 2-d Address Washington, D. C. 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Thrown from Auto when hit broadside by another car	20c. TIME OF INJURY Month, Day, Year 4:45 p.m. 6/18/61	20d. INJURY OCCURRED Where <input checked="" type="checkbox"/> Not Where <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nr. Ringold - Rt # 64	20f. (City or town) Wash.	20g. (County) MD	20h. (State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Dittmann		DATE SIGNED 6/18/61	
EXAMINER'S NAME (Type) Edward W. Dittmann		DEPUTY MEDICAL EXAMINER Charles L. Hines	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/61	
22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		22d. LOCATION (City, town, or country) (State) Prince Georges Co, Md.	
23. FUNERAL DIRECTOR The S.H.Hines Co. Washington, D.C.		24a. REC'D BY REGISTRAR DATE JUN 23 '61	
24b. REGISTRAR'S SIGNATURE Charles L. Hines			

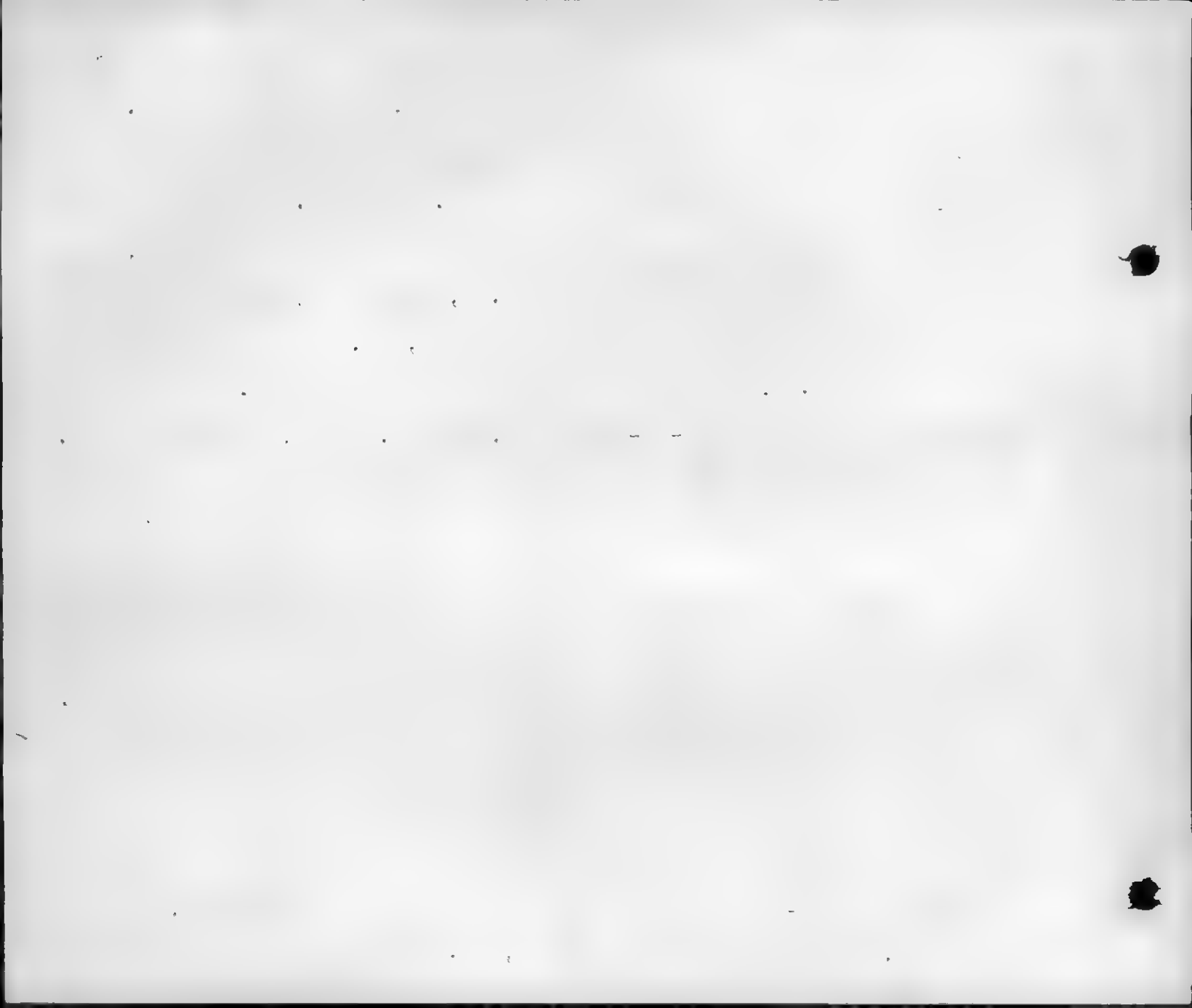


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7239

07227

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 14 E. Water St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Elbra Owen Brown				4. DATE OF DEATH Month June 18, Day 1961			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1894		9. AGE (In years last birthday) 67 yrs	10. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter		10b. KIND OF BUSINESS OR INDUSTRY aircraft		11. BIRTHPLACE (State or foreign country) Euclid, Md.		12. CITIZEN OF WHAT COUNTRY? UNKNOWN	
13. FATHER'S NAME John D. Brown				14. MOTHER'S MAIDEN NAME Ellen R. Wagaman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. WW I 217-03-2611		17. INFORMANT Address Mrs. Eula H. Brown, Smithsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Generalized Arteriosclerosis DUE TO (c) Small Bowel Obstruction, Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 15 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Small Bowel Obstruction, Uremia						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from JUNE 15 1961, to JUNE 18 1961, that (I) (we) last saw the deceased alive on JUNE 17 1961, and that death occurred at 5:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE E. P. Lardizabal		22b. PHYSICIAN'S NAME (Type) E. P. Lardizabal		22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Smithsburg, Md.		22e. DATE SIGNED 6-18-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6-20-61		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				25a. REC'D BY REGISTRAR DATE JUN 21 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Finner	





MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7241

07229

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FUNKSTOWN</u> d. STREET ADDRESS <u>111 STOEFFER AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>OMER - CLAY CLARK</u>				4. DATE DEATH <u>JUNE - 20 - 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>MAY 12 - 1884</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR Months <u>1</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE N.Y. CENTRAL IRON WORKS WASH. CO. MD.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>BENJAMIN F. CLARK</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE HARMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>MRS. BLANCHE CLARK</u> 17. INFORMATION <u>111 STOEFFER AVE FUNKSTOWN MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> 42011 DUE TO (b) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>Myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Emphysema senile - Center Right Lung</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>old</u>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>old</u>		20f. (City or town) (County) (State) <u>June 20, 1961</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1961</u> to <u>June 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1961</u> , and that death occurred <u>5:20 AM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidney Novenstein</u> M.D.				22b. DATE SIGNED <u>6-20-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>				22d. ADDRESS <u>Funkstown Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. BAST</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DR. NOVENSTEIN

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1 FOR STATE HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7242 37230											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Clarksburg</u> d. STREET ADDRESS <u>Box 1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Bobby Eugene Coffey</u> First Middle Last 4. DATE OF DEATH <u>June 15 19 61</u> Month Day Year						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>May 16, 1940</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>21</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Nursery</u> 11. BIRTHPLACE (State or foreign country) <u>Kings Mt. N. C.</u> 12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME <u>James Coffey</u> 14. MOTHER'S MAIDEN NAME <u>Edna Breakfield</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Mrs. Edna Coffey Clarksburg, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Neck.</u> DUE TO (b) <u>(C3 - C5 - C6 cervical vertebrae)</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dived 25 feet into shallow (4 ft) water</u> 20c. TIME OF INJURY Month, Day, Year <u>6 11 19 61</u> Hour a.m. p.m. <u>6 11</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Monocacy River</u> 20f. (City or town) <u>Clarksburg</u> (County) <u>Mont.</u> (State) <u>Md.</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>Edward W. Ditto III</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>6/16/61</u> Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>6-17-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Clarksburg Cemetery</u> 22d. LOCATION (City, town, or country) (State) <u>Clarksburg, Md.</u>											
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u> ADDRESS <u>Hagerstown, Md.</u> 24a. REC'D BY REGISTRAR <u>JUN 19 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Fries</u>											

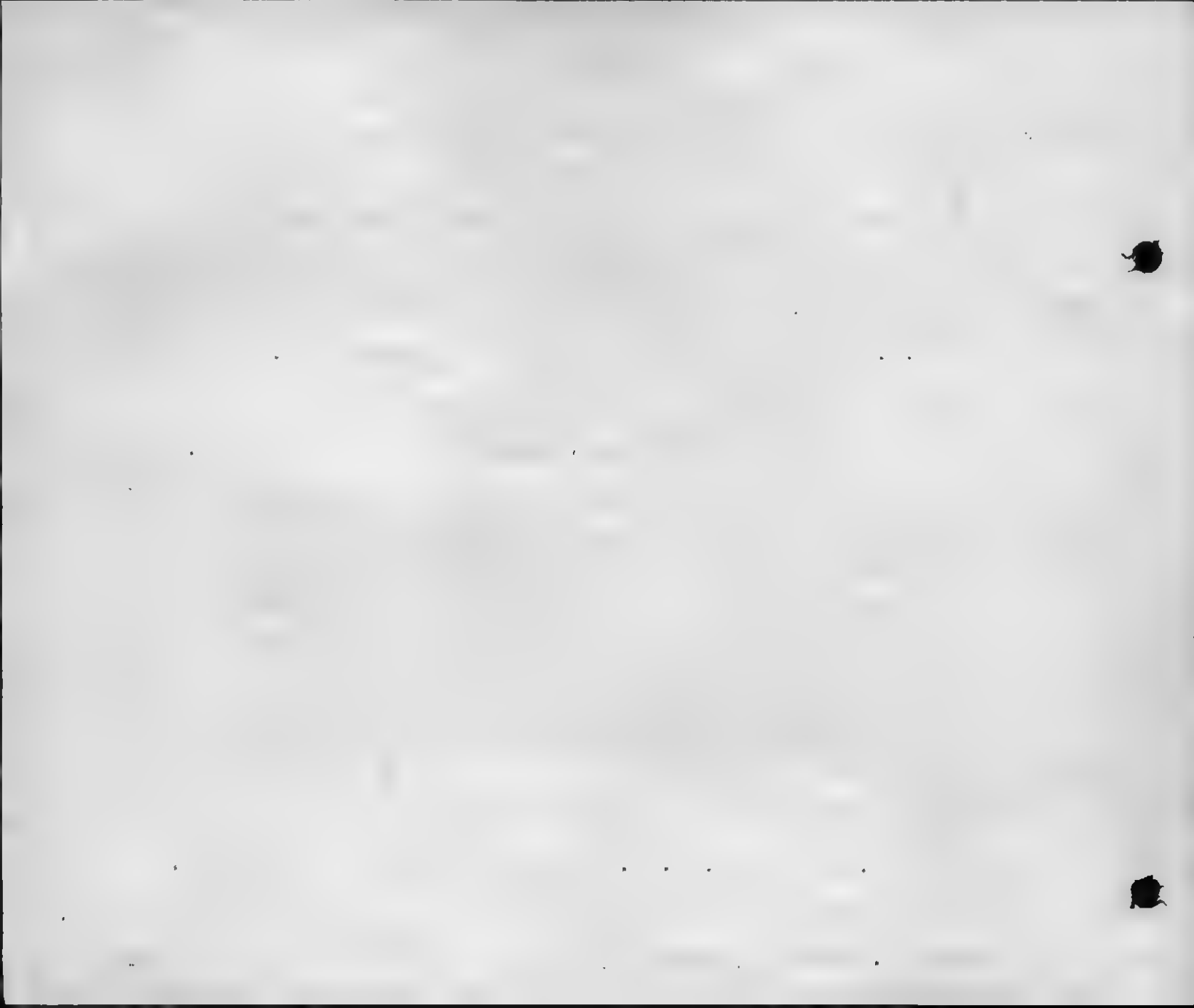
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TO PITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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<div> <div>7243</div> <div> <div>7231</div> <div>07231</div> </div> </div> <div> <div> <div>7243</div> <div>07231</div> </div> <div> <div>7243</div> <div>07231</div> </div> </div>																					
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN b. <u>9 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>906 Pope Ave</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>3003 Jefferson Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>CHARLES EDWARD CONER</u>						4. DATE OF DEATH <u>June 16 1961</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <th>Months</th> <th>Days</th> <th>Hours</th> <th>Min.</th> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penna R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Luray Paige Co Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>													
13. FATHER'S NAME <u>Edward Coner</u>						14. MOTHER'S MAIDEN NAME <u>Georgiana Burner</u>															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>717-07-9304</u> 17. INFORMANT <u>Lawson Burner Funkstown Md.</u>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. myocardial Infarction</u> (b) <u>420.0</u> DUE TO <u>general arteriosclerosis and</u> (c) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, }										INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>											
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																					
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from Aug. 1960, 1960, to June 16, 1961, that (I) (we) last saw the deceased alive on June 2 1961, and that death occurred at 8:30 PM, from the causes and on the date stated above.																					
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/16/61</u>													
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>						22d. ADDRESS <u>217 West Washington St.</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash DC Md.</u>															
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>						25a. REC'D BY REGISTRAR <u>JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>													



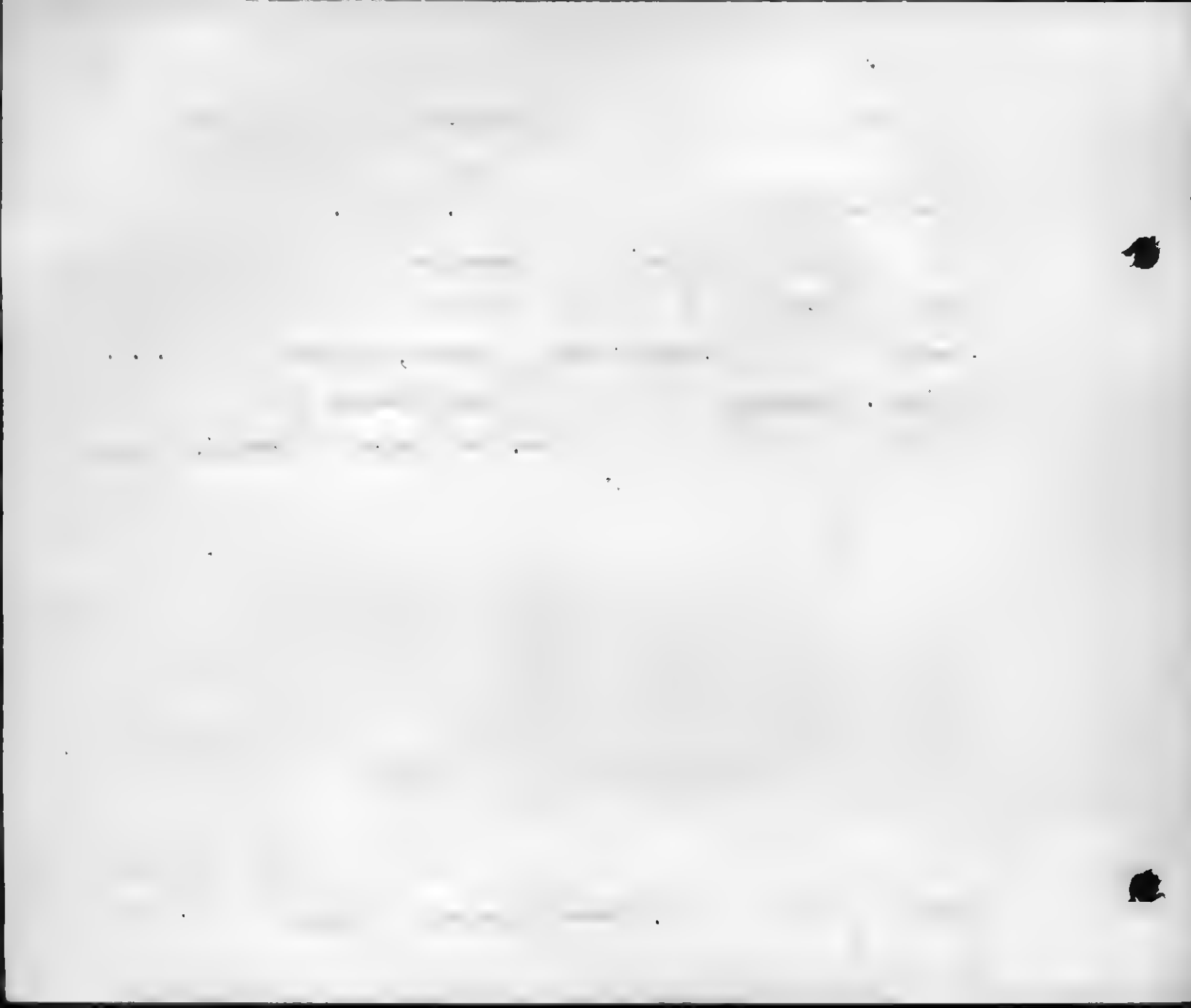
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7244

07232

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>			
c. LENGTH OF STAY IN 1b <u>18 days</u>				d. STREET ADDRESS <u>1145 W. Main St.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hancock Rest Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Byrd</u> Last <u>Connellus</u>		4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1961</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/2/1873</u>	9. AGE (In years last birthday) <u>87</u> yrs	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Hancock, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Connellus</u>		14. MOTHER'S MAIDEN NAME <u>Mary Catherine Dyer</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Mary Exline</u>		Address <u>Hancock, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular</u> <u>arteriosclerotic disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a m. <u> </u> p. m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>61</u> to <u>6/12</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/12</u> 19 <u>61</u> , and that death occurred at <u>4:37</u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>M. Shaffer</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u> </u>			
22c. PHYSICIAN'S NAME (Type) <u>M. SHAFER</u>		22d. ADDRESS <u>Hancock Md</u>					
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u>		23d. LOCATION (City, town, or county) (State) <u>Hancock Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Stone Hancock Md</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>William S. Stone</u>	
				DATE <u>JUN 19 1961</u>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with _____ hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7245

07233

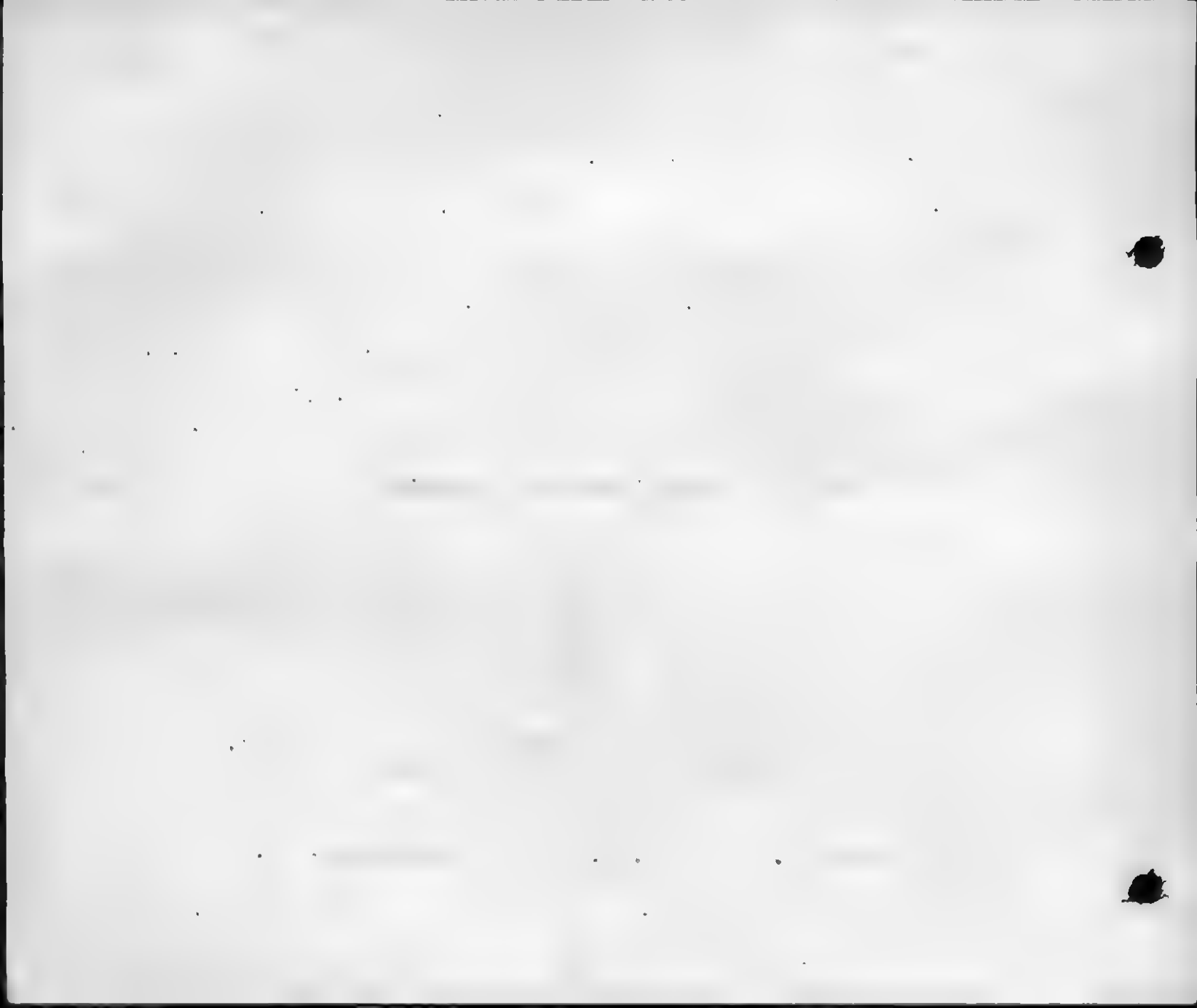
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg				c. LENGTH OF STAY IN 1b 82 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 W. antietam Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle Albert Last Crampton				4. DATE OF DEATH Month June Day 7 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 13 1878	
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 8 Days 24		11. IF UNDER 24 HRS Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Game Warden Conservation				10b. KIND OF BUSINESS OR INDUSTRY Maryland State		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A							
13. FATHER'S NAME John Crampton				14. MOTHER'S MAIDEN NAME Francis E. SAYLOR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Edgar Crampton		Address 206 W. Antietam St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia 24.3 DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 2 months							
MEDICAL CERTIFICATION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from 4/11/61 19____, to 6/7/61 19____, that (I) (we) last saw the deceased alive on 6/11/61 19____, and that death occurred at 9 P M, from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Shealy				22b. ADDRESS Sharpsburg, Md.		22c. DATE SIGNED 6/9/61	
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.				22d. ADDRESS Sharpsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 10-61		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) _____ (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE Albert Lee Williams				25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE William S. Thomas	

M

X

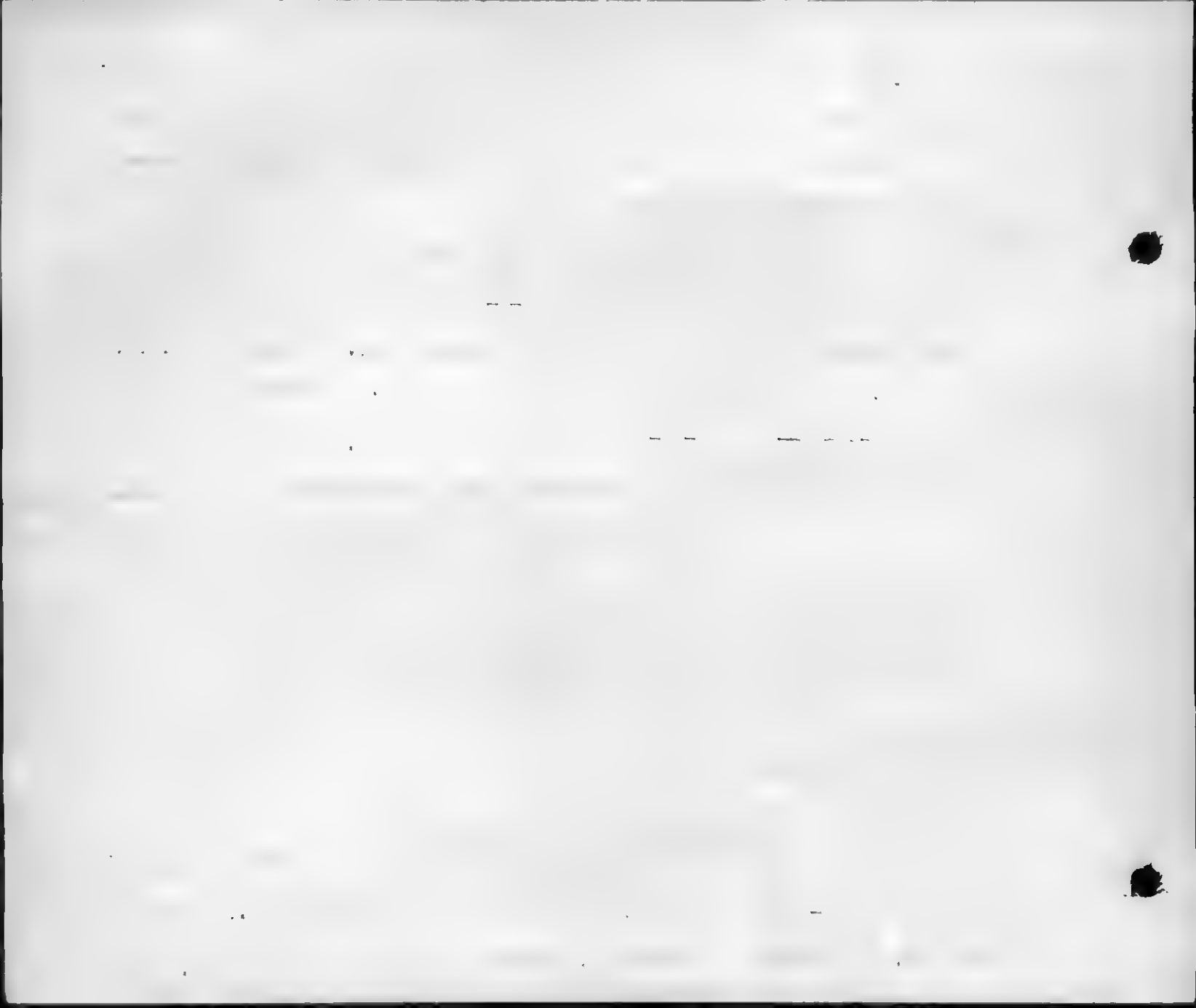
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7246
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07234

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ELmer Richard CREBBS				4. DATE OF DEATH Month Day Year 6 3 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1886	9. AGE (In years last birthday) 75 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John D. Crebbs				14. MOTHER'S MAIDEN NAME Margaret L. Holzapfel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-6589		17. INFORMANT Address Raymond Crebbs Rt.# 7 Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident DUE TO Essential hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH one month unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 24, 1961 to June 3, 1961 , that (I) last saw the deceased alive on June 3, 1961 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Young E. Chun M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED June 3, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN				22d. ADDRESS 1500 Penna Ave Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-1961		23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		23d. LOCATION (City, town, or county) (State) Frederick Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son				ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR JUN 6 '61	
				25b. REGISTRAR'S SIGNATURE William S. Kraus			



FOR STATE
HEALTH DEPT.

M

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health.
its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7247 07235											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN Ia D.O.A.				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Pleasantville			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				Id STREET ADDRESS Hoffmaster Road				b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELLEN LUCINDA DILLOW				4. DATE OF DEATH Month June Day 25, Year 19 61							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1906		9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Samples Manor, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Barton Hanes				14. MOTHER'S MAIDEN NAME Annie Weaver							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No None				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Virgie Mae Carey Brownsville, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO LOBULAR PNEUMONIA, BILATERAL W/ABSCESS FORMATION DEHYDRATION (b) DUE TO (c) DUE TO BARBITURATE INTOXICATION? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)										INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 5 DAYS	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) DR. E. W. DITTO, JR				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				DATE SIGNED 6/25/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/61		22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or county) (State) Samples Manor, Maryland					
23. FUNERAL DIRECTOR Harper's Ferry, West Va.				24a. REC'D BY REG. STRAR DATE JUN 27 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hanes					

THE
FEDERAL
BUREAU OF
INVESTIGATION
OF THE
DEPARTMENT OF JUSTICE

UNITED STATES

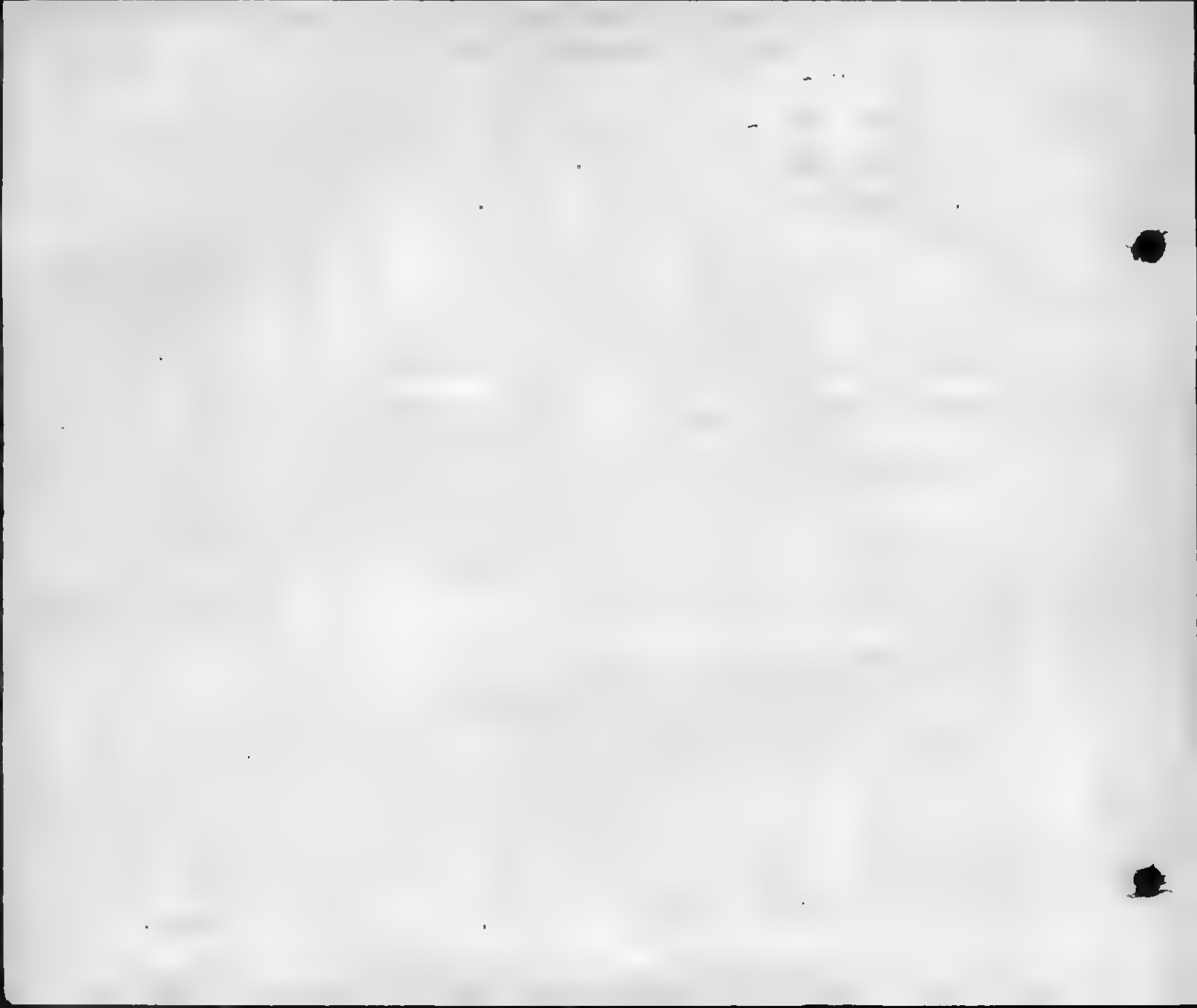
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **67236**

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT.#1 HAGERSTOWN				d. STREET ADDRESS RT.#1 HAGERSTOWN			
3. NAME OF DECEASED (Type or print) First JOHN Middle DOCHERTY Last				4. DATE OF DEATH Month JUNE Day 17 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 1/15/1882		9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 7 Days 15 Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY FLOOR COVERINGS		11. BIRTHPLACE (State or foreign country) SCOTLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES DOCHERTY					
14. MOTHER'S MAIDEN NAME CHRISTINIA JAMESON		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO					
16. SOCIAL SECURITY NO.		17. INFORMANT Address BALTIMORE MD. MR. ROBERT DOCHERTY					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) 470.1 Heart Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (b) general arterio-sclerosis and (c) arterio-sclerotic heart disease DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE Edward W. Ditto III M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/18/61			
EXAMINER'S NAME (Type) Edward W. Ditto III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/20/61		22c. NAME OF CEMETERY OR CREMATORY LAWN CROFT CEM.			
22d. LOCATION (City, town, or county) LINWOOD PENNA.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horne, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE JUN 20 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Hume							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If one day is necessary, please are-
 culate the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be
 forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation,
 or removal.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

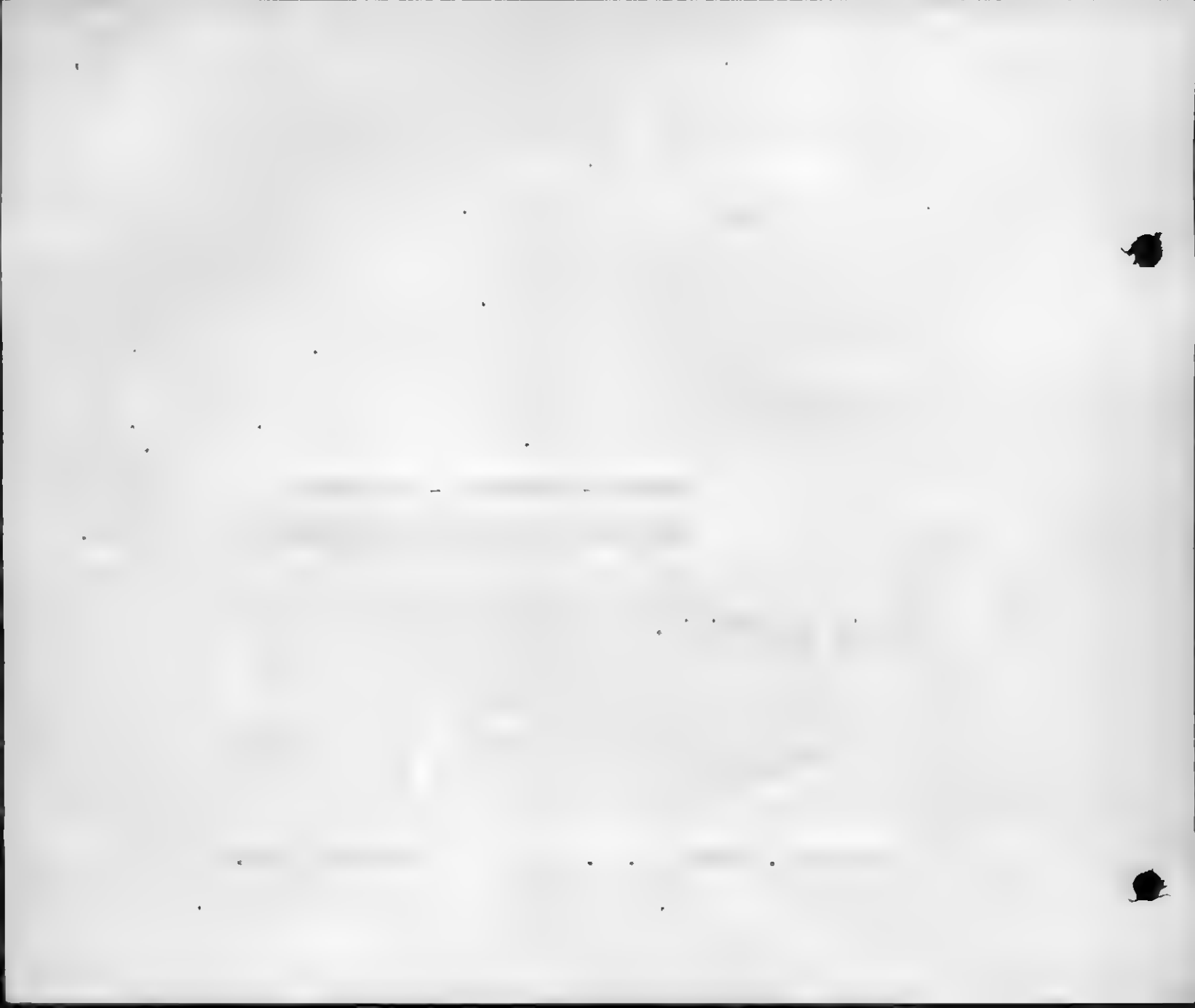
07237

7249

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg				c. LENGTH OF STAY IN 1b 66 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 E. Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Arthur Middle Howell Last Dorsey				4. DATE OF DEATH Month June Day 21 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21 1894	
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 10 Days 6 Hours 0 Min.		11. BIRTHPLACE (State or foreign country) Sharpsburg Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President & Cashier Bank				10b. KIND OF BUSINESS OR INDUSTRY Sharpsburg Md.			
13. FATHER'S NAME Charles Christian Dorsey				14. MOTHER'S MAIDEN NAME Anna Martha Stine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. #1 216 07 7098		17. INFORMANT Mrs. Edna Dorsey Address 121 E. Main St. Sharpsburg Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Broncho-pneumonia - terminal 02.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema and chronic bronchitis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 Yrs.						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a m p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 1958 , to 6/21/61 , 19 61 , that (I) (we) last saw the deceased alive on 6/21/61 , 19 61 , and that death occurred at 4 PM , from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Shealy				22b. DATE SIGNED 6/23/61			
22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.				22d. ADDRESS Sharpsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24-61		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leg Williamsport, Md				25a. REC'D BY REGISTRAR JUN 26 '61		25b. REGISTRAR'S SIGNATURE C. L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

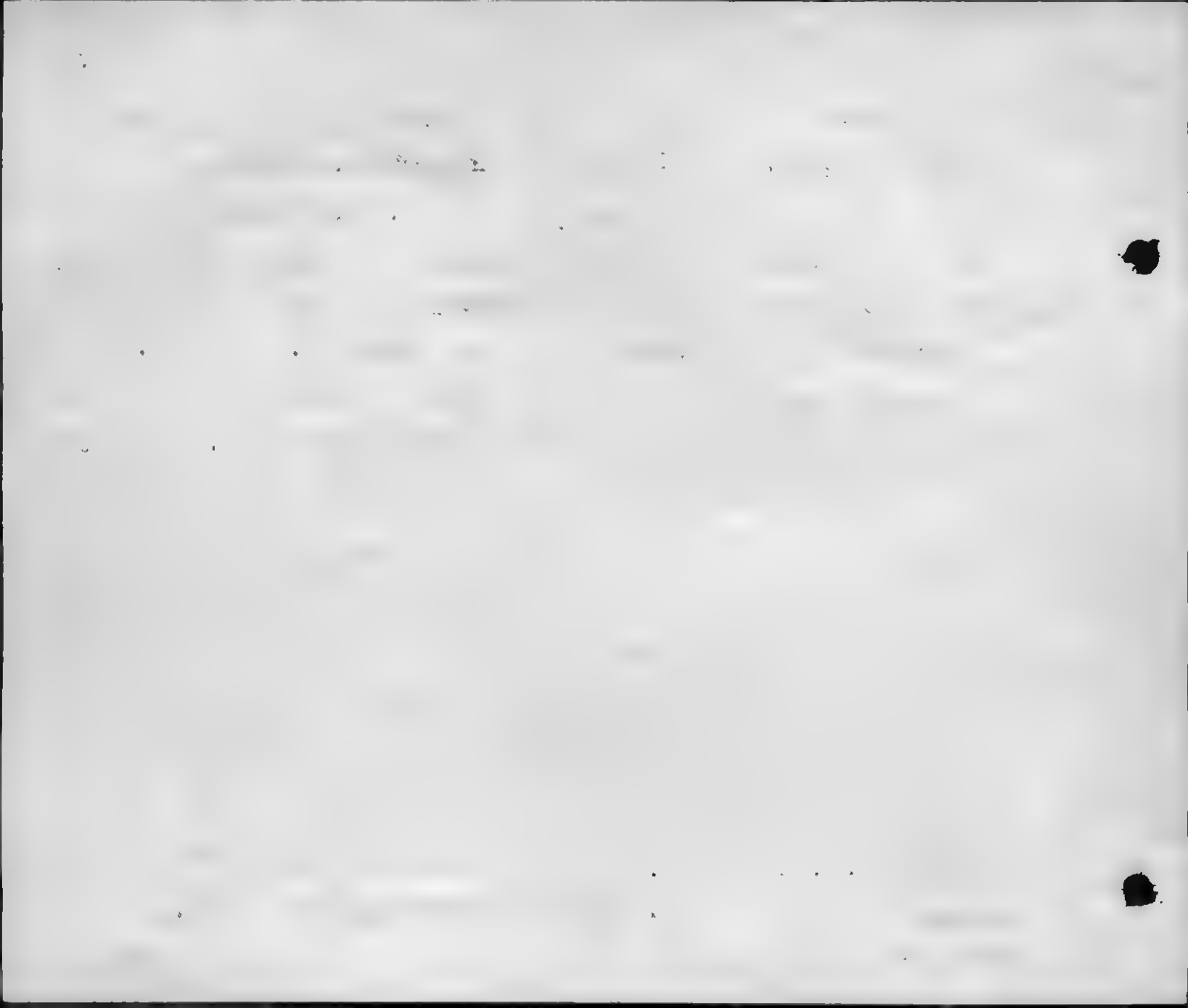
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



C7238

7250

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. c. LENGTH OF STAY IN TB 11 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dead on arrival Washington County Hosp.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS 130 W. Bethel Street	
3. NAME OF DECEASED (Type or print) Luther Edward Dorsey 5. SEX Male 6. COLOR OR RACE Colored 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH Mar 16 1913 9. AGE (in years last birthday) 43 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman 10b. KIND OF BUSINESS OR INDUSTRY Church 11. BIRTHPLACE (State or foreign country) Cooksville, Md. 12. CITIZEN OF WHAT COUNTRY USA.		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> 4. DATE OF DEATH June 12 1961 6. DATE OF BIRTH Mar 16 1913 9. AGE (in years last birthday) 43 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman 10b. KIND OF BUSINESS OR INDUSTRY Church 11. BIRTHPLACE (State or foreign country) Cooksville, Md. 12. CITIZEN OF WHAT COUNTRY USA.	
13. FATHER'S NAME Joseph Dorsey 14. MOTHER'S MAIDEN NAME Maria Prettyman		13. FATHER'S NAME Joseph Dorsey 14. MOTHER'S MAIDEN NAME Maria Prettyman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-14-5853 17. INFORMANT Mrs. Dorothy Dorsey Address 130 W. Bethel St.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 212-14-5853 17. INFORMANT Mrs. Dorothy Dorsey Address 130 W. Bethel St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Atherosclerosis, Severe DUE TO (c) Cardiac Hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: None		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Coronary Atherosclerosis, Severe DUE TO (c) Cardiac Hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: None	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Dr. E. W. Dille, Jr. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6-18-1961 22c. NAME OF CEMETERY OR CREMATORY St. Gregory Cemetery 22d. LOCATION (City, town, or country) (State) Cooksville, Md.		21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . ACTUAL SIGNATURE [Signature] M.D. EXAMINER'S NAME (Type) Dr. E. W. Dille, Jr. 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 6-18-1961 22c. NAME OF CEMETERY OR CREMATORY St. Gregory Cemetery 22d. LOCATION (City, town, or country) (State) Cooksville, Md.	
23. FUNERAL DIRECTOR John R. Watson ADDRESS Hagerstown, Md.		23. FUNERAL DIRECTOR John R. Watson ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR [Signature] DATE JUN 19 1961		24a. REC'D BY REGISTRAR [Signature] DATE JUN 19 1961	
24b. REGISTRAR'S SIGNATURE Arthur S. Hines		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

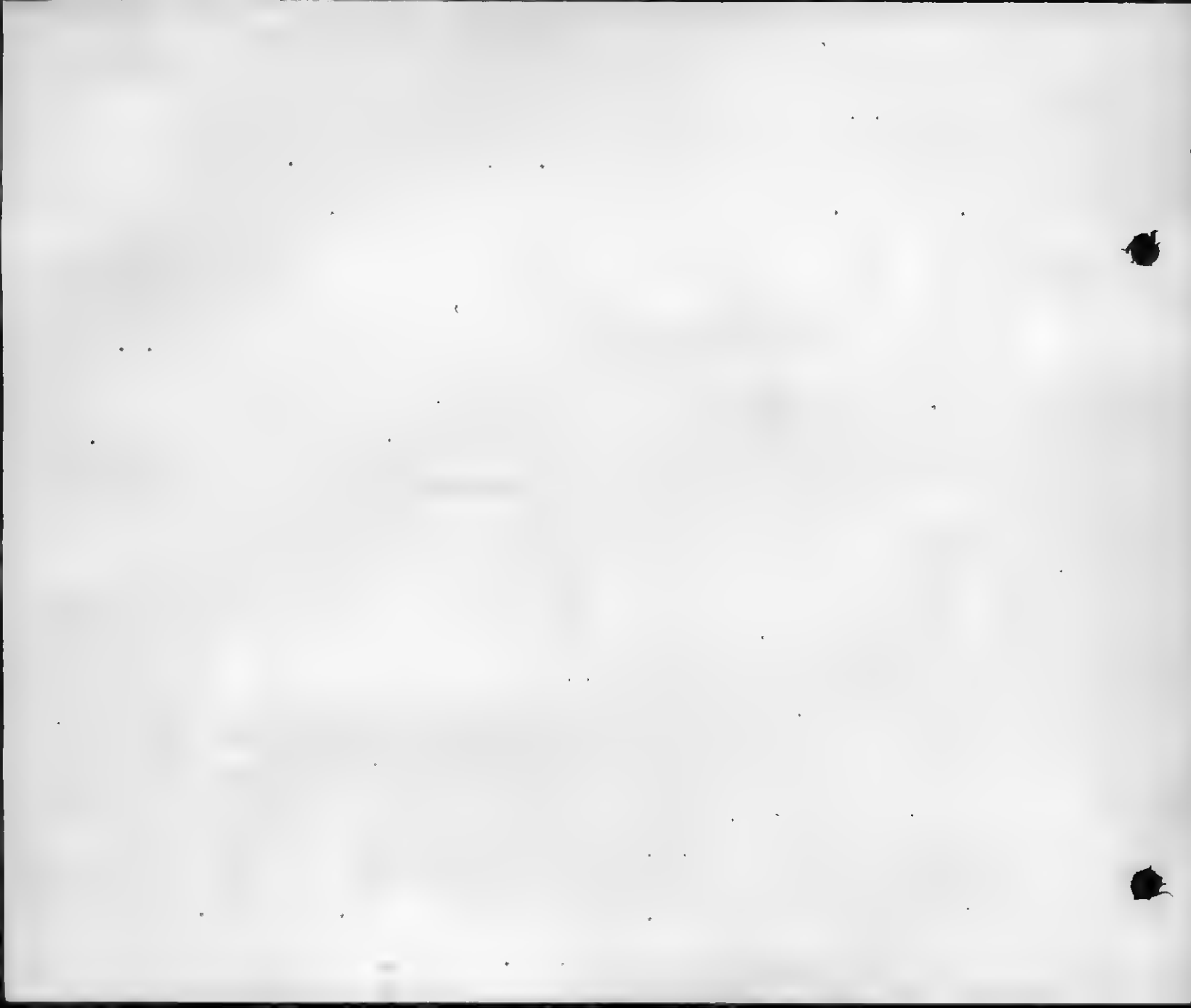
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07239

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING c. LENGTH OF STAY IN 1b OVER 50 YRS. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. MILL ST.				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. d. STREET ADDRESS CUMBERLAND ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARY LOOSE DOWNS				4. DATE OF DEATH Month Day Year JUNE 30 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT 22, 1879	
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR Months 8 Days 8		11. IF UNDER 24 HRS. Hours 8 Min. 8			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES				10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) PEABODY, KANSAS	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DR. CYRUS LOOSE				14. MOTHER'S MAIDEN NAME ALICE SPANGLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address CHARLES DOWNS CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction to coronary artery occlusion DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 12-2-0 DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Fracture hip right, due to fall at home 20 May 1961							
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell at home... 20 May 1961							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:30 a.m. 19 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Clear Spring Washington Md.	
21 I certify that (I) (this hospital) attended the deceased from 20 May 1961 to 30 June 1961 , that (I) (we) last saw the deceased alive on 30 June 1961 19 19 , and that death occurred at 11:55 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.				22b. DATE SIGNED 2 July 1961			
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				22d. ADDRESS Clear Spring, Maryland			
23a. BURIAL CREMATION REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 3, 1961		23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town, or county) (State) ST. PAUL, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Margaret Rowland</i> CLEAR SPRING, MD.				25a. REC'D BY REGISTRAR JUL 5 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

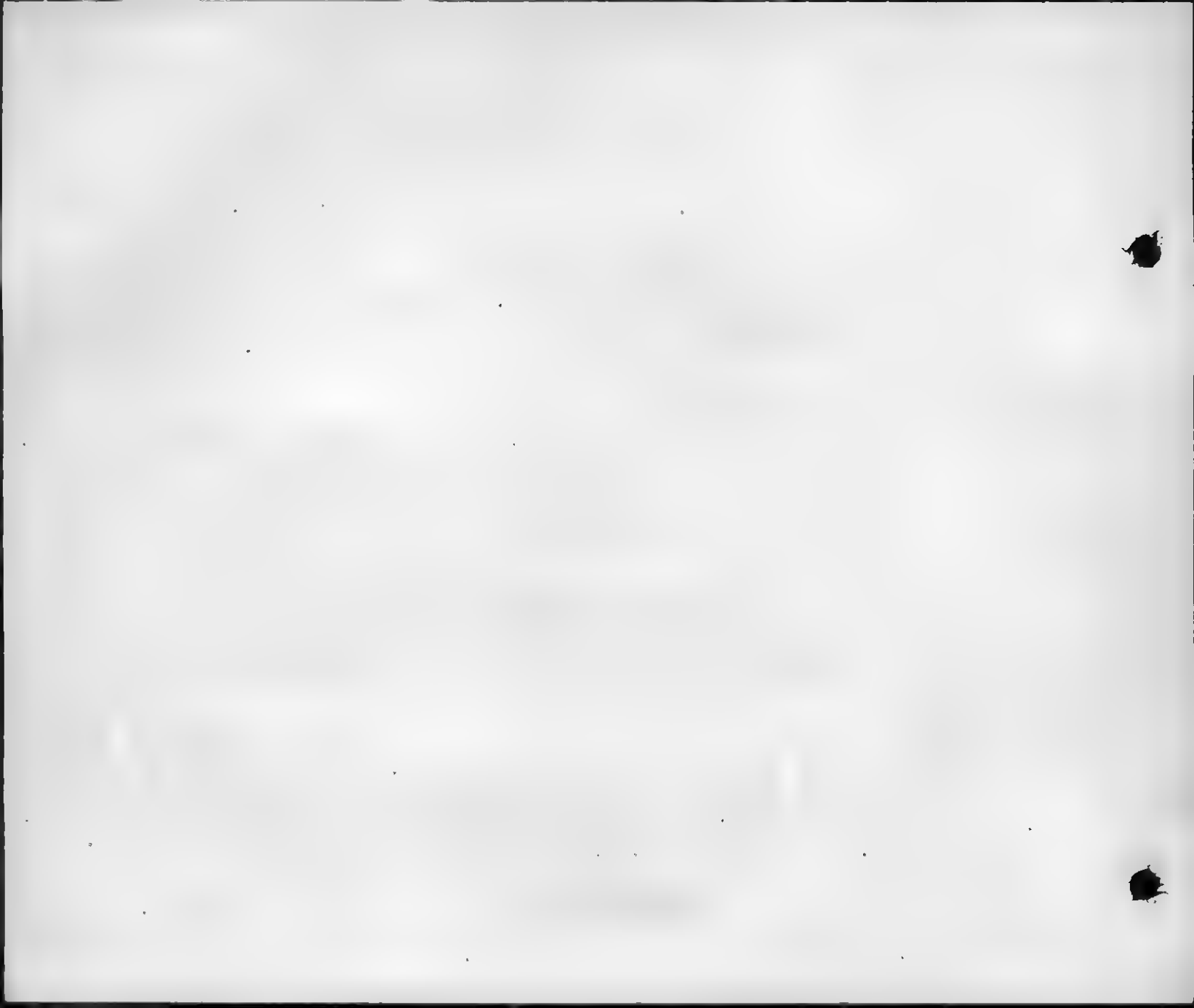
7252

07240

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1827 Sheridan Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Olla Middle Victoria Last Edwards		4. DATE OF DEATH Month June Day 24 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1895
9. AGE (In years last birthday) 66 yrs		10. IF UNDER 1 YEAR Months 66 Days 66 Hours 66 Min 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory	
11. BIRTHPLACE (State or foreign country) Woodstock, Va.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Harvey Hoffman		14. MOTHER'S MAIDEN NAME Margaret Dunkin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 214-09-0471	
17. INFORMANT Mr. Robert E. Edwards		Address Hagerstown, md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 16211 DUE TO Brochogenic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 16211 DUE TO 16211 (c) 16211 INTERVAL BETWEEN ONSET AND DEATH 15 weeks			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 16211 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from May 23 1961 , to June 24 1961 , that (I) (we) last saw the deceased alive on June 24 1961 , and that death occurred at 9p.m. from the causes and on the date stated above.			
22a. SIGNATURE Walter Layman		22b. DATE SIGNED June 26, 1961	
22c. PHYSICIAN'S NAME (Type) W. Walter Layman, M. D.,		22d. ADDRESS 100 Professional Arts Bldg., Hagerstown, Maryland.	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6-27-61	
23c. NAME OF CEMETERY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR JUN 27 61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7253
7253
CERTIFICATE OF DEATH
07241

1 PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
f. STREET ADDRESS 213 JEFFERSON ST.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last TREBE CLYDE ERNDE				4. DATE OF DEATH Month Day Year JUNE 7 19 61			
5 SEX MALE		6 COLOR OR RACE WHITE		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/11/1889	
9. AGE (In years last birthday) 72 ^{rs}		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WATER DEPT. PUMPING STATION				10b. KIND OF BUSINESS OR INDUSTRY MARYLAND			
11 BIRTHPLACE (State or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13 FATHER'S NAME LEWIS ERNDE				14 MOTHER'S MAIDEN NAME EMMA TRACEY			
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-09-4725			
17 INFORMANT MISS MAXINE ERNDE				Address HAGERSTOWN MD.			
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2 <i>Cerebral Hemorrhage</i> DUE TO <i>Arteriosclerosis general</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Diabetes mellitus</i> DUE TO (c) <i>Gangrene - Rt foot</i> INTERVAL BETWEEN ONSET AND DEATH 4 days. 1 mo.							
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c TIME OF INJURY Month Day Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21 I certify that (I) (this hospital) attended the deceased from June 18 1961, to June 20 1961, that (I) (we) last saw the deceased alive on June 7 1961, and that death occurred at 10 M, from the causes and on the date stated above.							
22a SIGNATURE <i>Philip J. Hirshman</i>				22b DATE SIGNED 6/8/61			
22c PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.				22d ADDRESS 159 W. Washington St. Hagerstown, Maryland			
23a BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b DATE THEREOF 6/9/61		23c NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24 FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Norment</i>				25a REC'D BY REGISTRAR 25b REGISTRAR'S SIGNATURE <i>William E. Finner</i>			
ADDRESS Hagerstown, Md.				DATE JUN 12 '61			

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MEDICAL CERTIFICATION

VS. A15ME(5)
SM 9/55



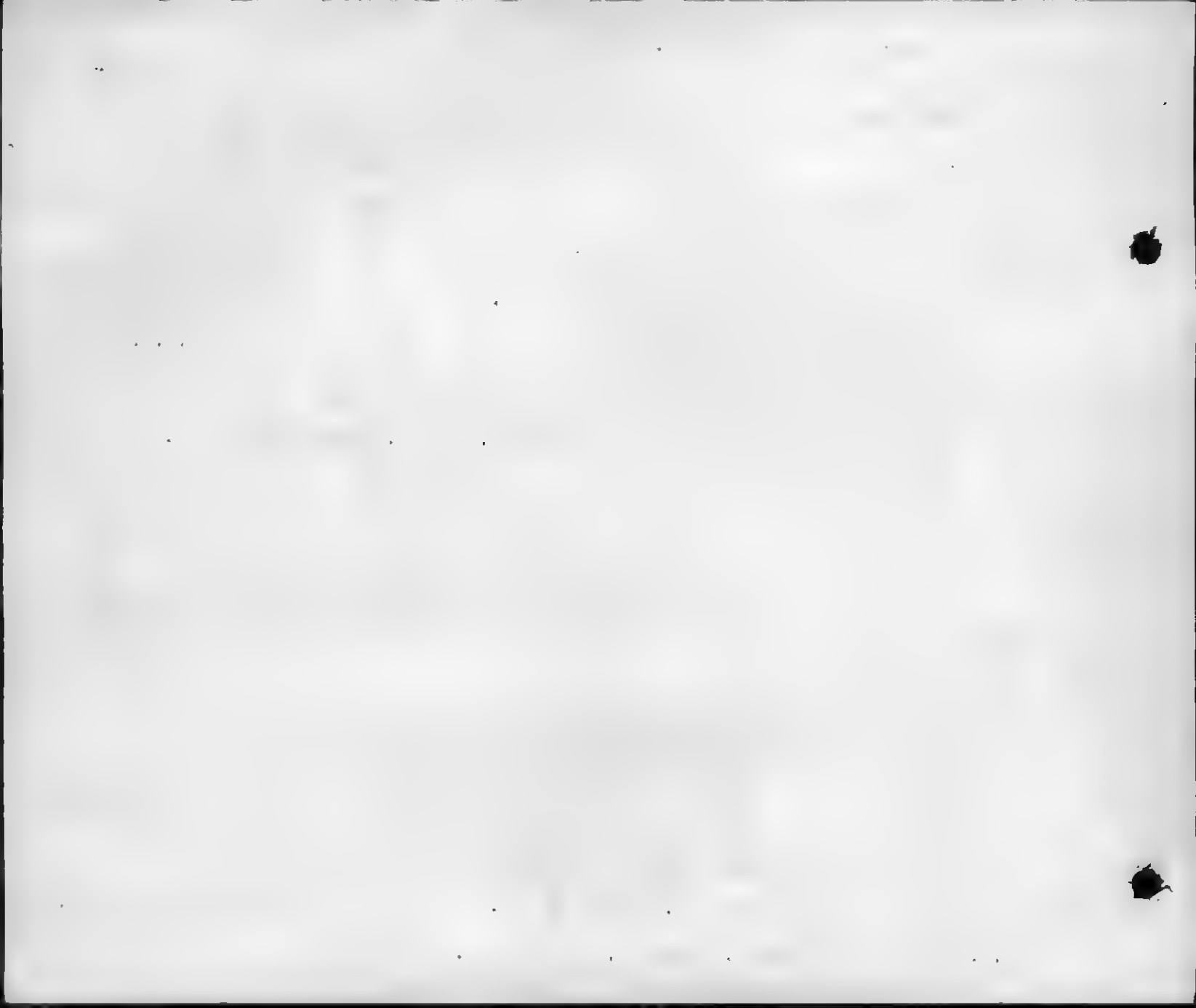
DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7255

07244

1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Point of Rocks			
f. STREET ADDRESS Point of Rocks				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last HELEN IRENE FORD				4. DATE OF DEATH Month Day Year JUNE 28, 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1924		9. AGE (In years last birthday) yrs. 36	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Point of Rocks, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Quincy Lowery				14. MOTHER'S MAIDEN NAME Lena Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO Unk		17. INFORMANT James S. Ford, Sr. Adamstown, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary hemorrhage 171 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary metastasis DUE TO (c) carcinoma of cervix							INTERVAL BETWEEN ONSET AND DEATH 5 min. unknown 3 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Hydronephrosis							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from JUNE 19, 1961 , to JUNE 28, 1961 , that (I) (we) last saw the deceased alive on JUNE 28, 1961 , and that death occurred at 5:48 PM , from the causes and on the date stated above							
22a. SIGNATURE Victor L. Ramos, M.D.		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED JUNE 29, 1961			
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 3, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery.		23d. LOCATION (City, town, or county) (State) Point of Rocks, Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, 106 E. Church St. Frederick, Md.				25a. REC'D BY REGISTRAR DATE JUL 3 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Pages 1 and 2 should be filed with the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7256

07245

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 45 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 428 W. Franklin Street			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 428 W. Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle FREDERICK Last FOREMAN, JR.			4. DATE OF DEATH Month June Day 23 Year 1961		
5. SEX male			6. COLOR OR RACE white		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH February 26, 1894		
9. AGE (In years last birth day) 67 yrs.			10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours M'n.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Construction worker Contractor			10b. KIND OF BUSINESS OR INDUSTRY Shady Grove, Pennsylvania U.S.A.		
11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Abraham Frederick Foreman, Sr.			14. MOTHER'S MAIDEN NAME Cornelia Loy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes W.W. I			16. SOCIAL SECURITY NO. 217-10-3439		
17. INFORMANT Mrs. Winona Ridenour			Address Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma (Rt Lung) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 Yr +		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. City or town (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb 1, 1961, to June 23, 1961, that (I) (we) last saw the deceased alive on June 22, 1961, and that death occurred at 9 AM, from the causes and on the date stated above.					
22a. SIGNATURE F.F. Lusby			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) F.F. Lusby			22d. ADDRESS 230 W Potomac St Hagerstown Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/26/1961		
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Greencastle Pa.		
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home			25a. REC'D BY REGISTRAR DATE JUN 28 '61		
ADDRESS Hagerstown, Md.			25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

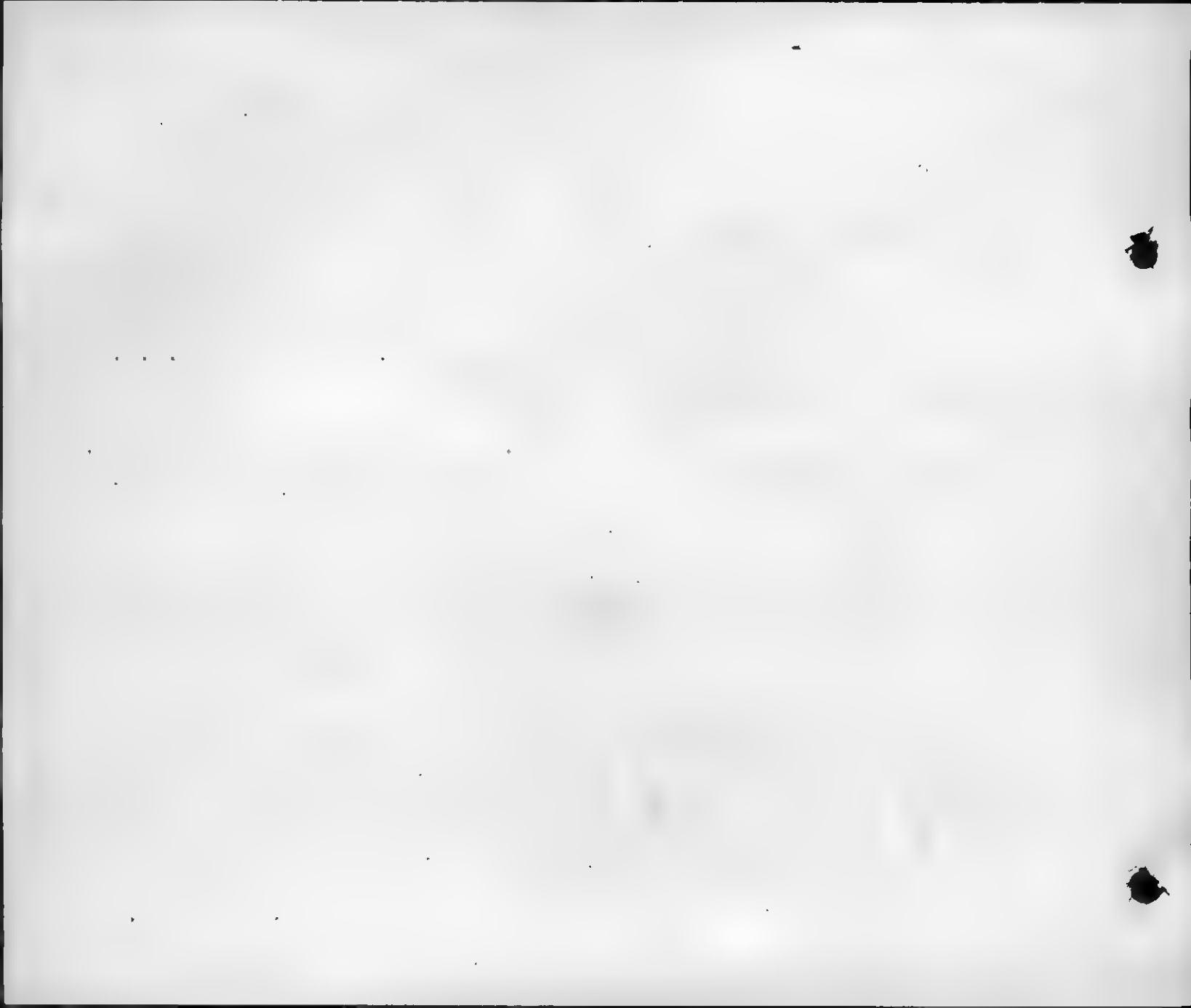
VR A15 (4)
15M 11/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7257

07246

1 PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West High Street		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock d. STREET ADDRESS West High Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Annie Louise French		4. DATE OF DEATH Month Day Year 6 25 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/1874
9. AGE (In years last birthday) 86 yrs		10. IF UNDER 1 YEAR Months Days Hours Min 8 25 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Big Pool, Maryland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Manning		14. MOTHER'S MAIDEN NAME Amelia Otto	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No	
17. INFORMANT Mrs. Gant Johnson		Address Big Pool, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Acute Passive Heart Failure DUE TO (b) Acute Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		INTERVAL BETWEEN ONSET AND DEATH 8 hrs 8 hrs 15 yrs.	
21. I certify that (I) (this hospital) attended the deceased from 6-29 1961 to 6-25 1961, that (I) (we) lost saw the deceased alive on 6-25 1961, and that death occurred 6-27 1961, from the causes and on the date stated above.		22a. SIGNATURE F.B. Thomas III M.D. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) F.B. THOMAS III M.D. 22d. ADDRESS HANCOCK, Md. 22b. DATE SIGNED 6-27-61	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/61	
23c. NAME OF CEMETERY OR CREMATORY Shanks Town EUB		23d. LOCATION (City, town, or county) (State) Shank Town Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Hansel J. Elmer Hancock Md		25a. REC'D BY REGISTRAR JUN 29 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

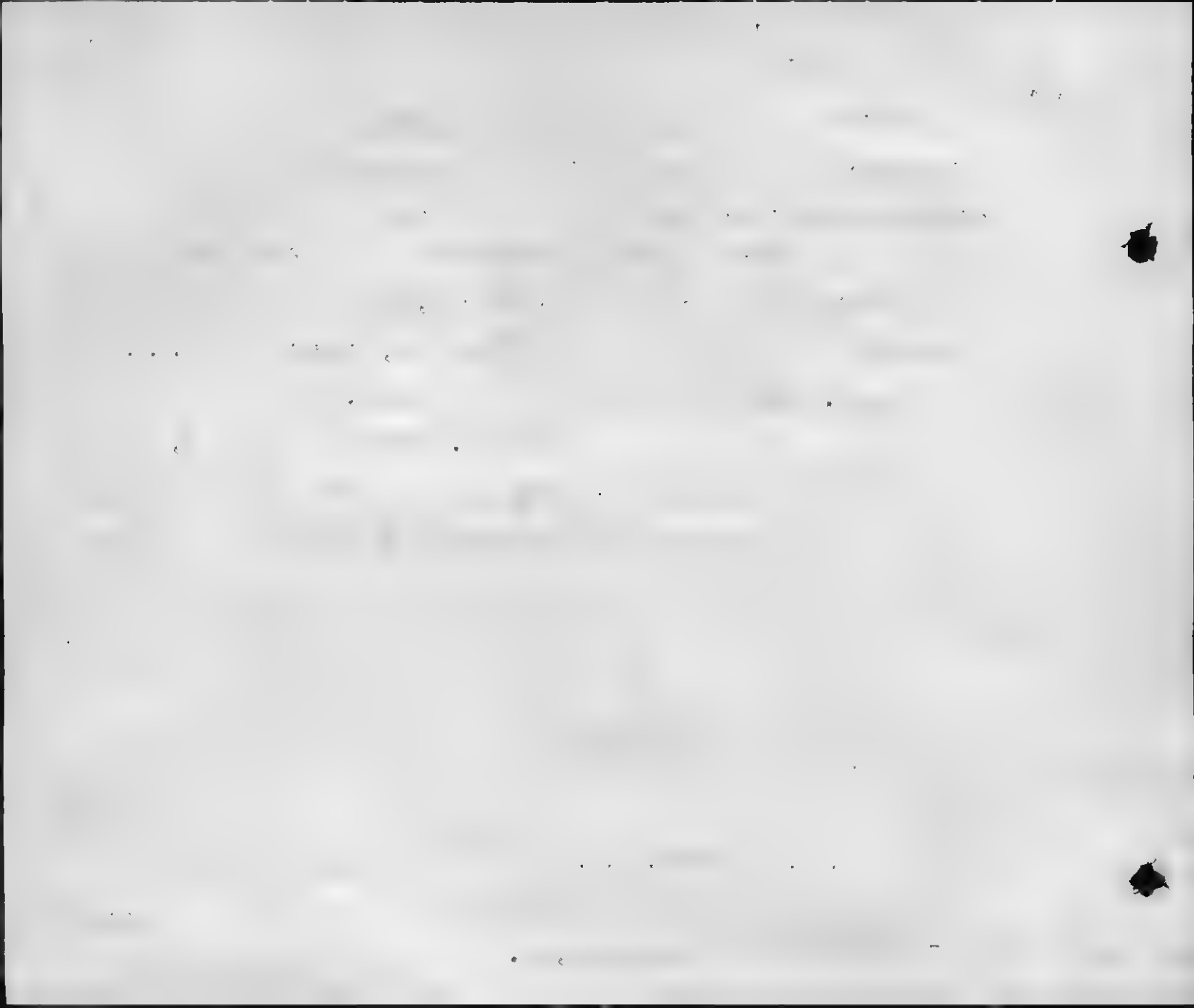
CERTIFICATE OF DEATH

7258

07247

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>most of life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Jackson Convalescent Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>136 Broadway</u>			
3. NAME OF DECEASED (Type or print) <u>EDITH ALMA FUNKHOUSER</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>October 14, 1876</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Winchester, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Marcus J. Snapp</u>				14. MOTHER'S MAIDEN NAME <u>Zora V. Gay</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>George D. Funkhouser</u> 17. INFORMANT <u>Hagerstown, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVA. BETWEEN ONSET AND DEATH <u>3 weeks</u> Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) _____							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 4 1961</u> to <u>June 6 1961</u> that (I) (we) saw the deceased alive on <u>June 4 1961</u> , and that death occurred at <u>3:48 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u>				22b. DATE SIGNED <u>6/7/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/8/1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Franklin Berger</u>				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <u>June 12 '61</u>			

TO INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the Health certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

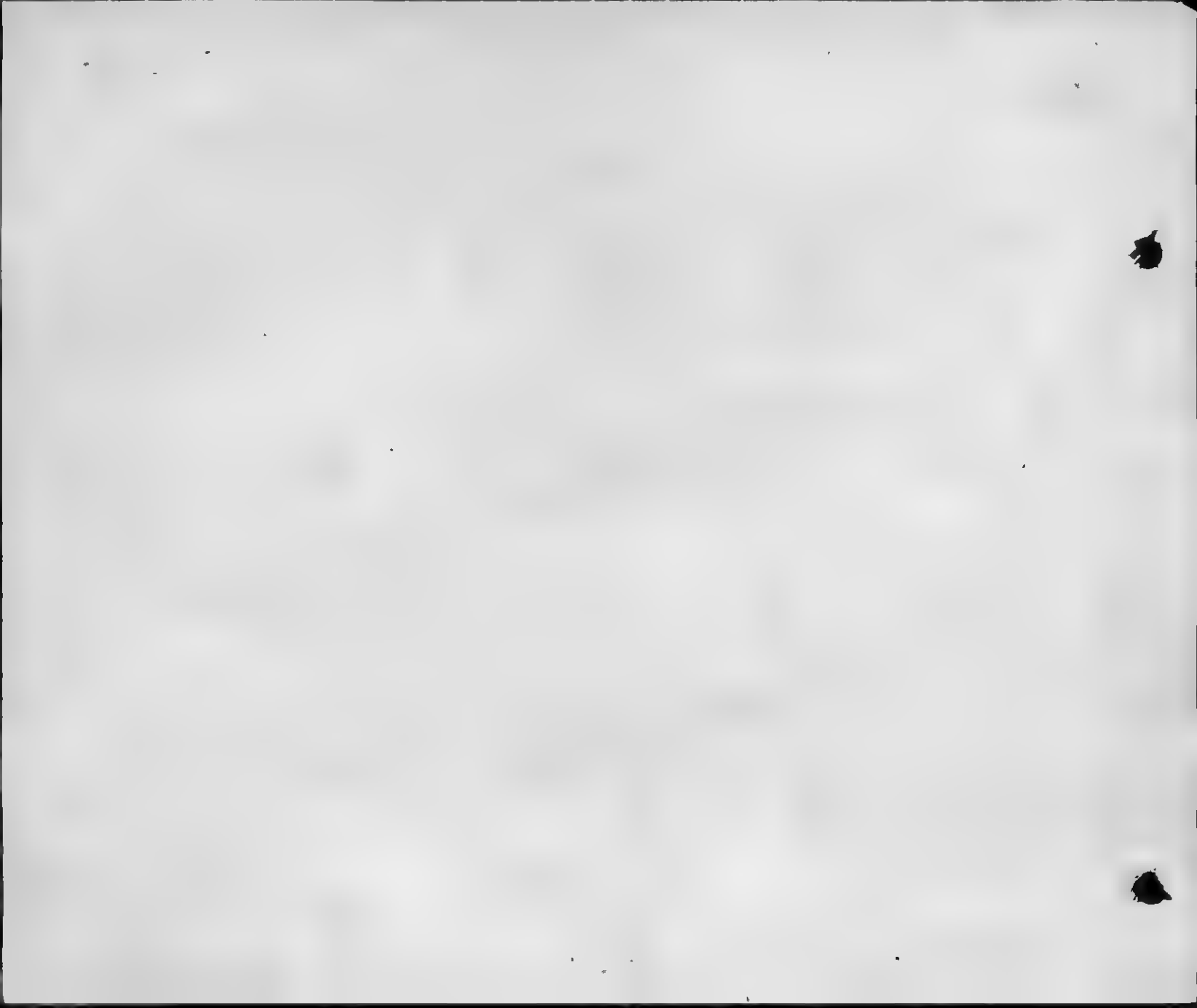
7259

67248

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY (N 1/2) <u>6 Hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>901 Chestnut St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>DAVID ALBERT GOSSARD</u>		4. DATE OF DEATH <u>June 19 1961</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 22 1877</u> 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Hag Dairy Co</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Welsh Run Franklin Co Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Theodore Gossard</u> 14. MOTHER'S MAIDEN NAME <u>Josephene Barnes</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war and dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-09-2837</u> 17. INFORMANT <u>Mrs Myrtle M. Gossard</u> Address <u>901 Chestnut St Hagerstown Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden coronary occlusion</u> 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Generalized atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>Unknown</u> <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 15</u> <u>1952</u> <u>to June 19</u> <u>1961</u> , that (I) (we) last saw the deceased alive on <u>June 19</u> <u>1961</u> , and that death occurred at <u>3:15 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L L Parker J</u>		22b. DATE SIGNED <u>6/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Washington</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>	

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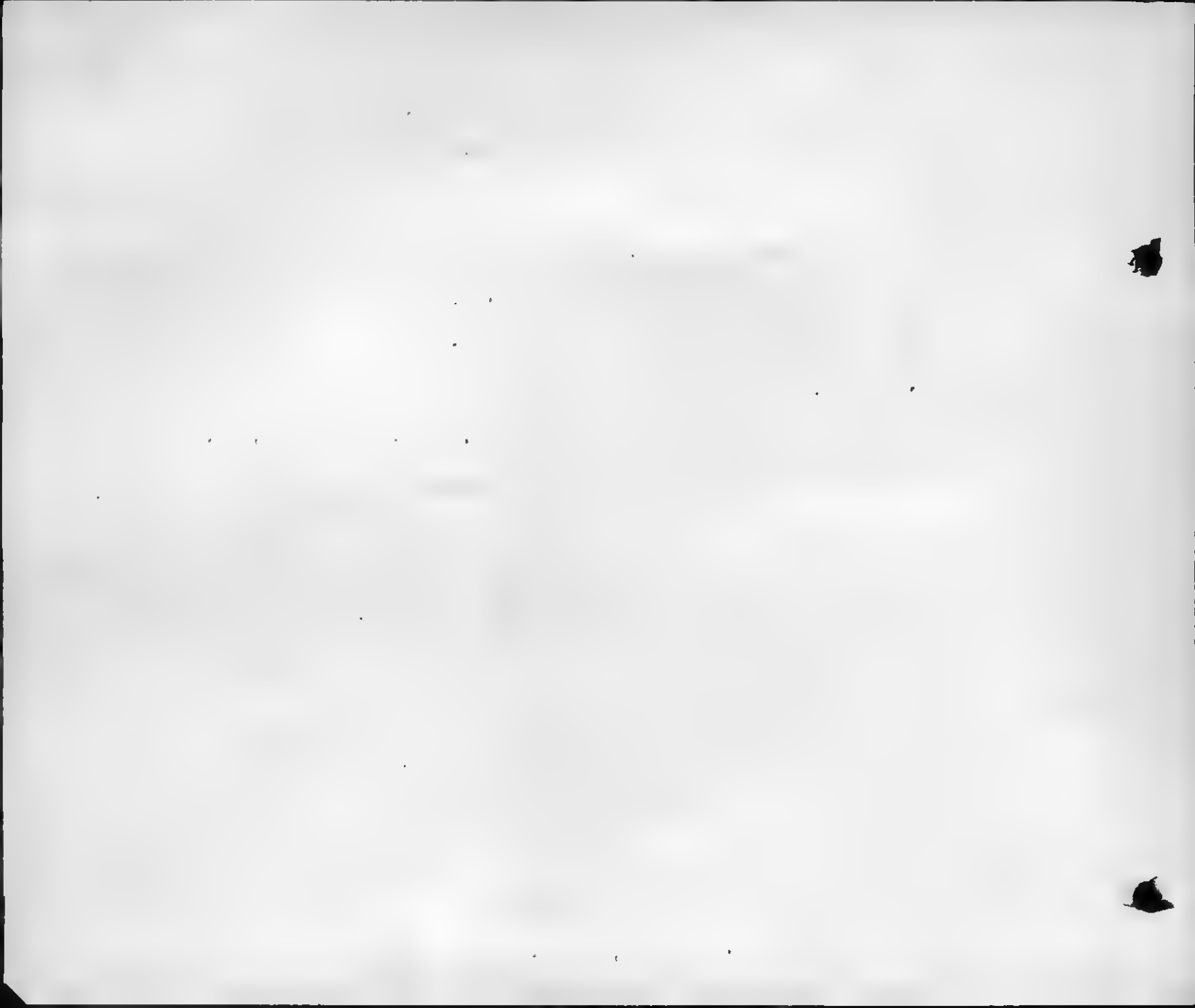
CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7260

07249

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Rural - Smithsburg d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Smithsburg d. STREET ADDRESS RD # 2	
3. NAME OF DECEASED (Type or print) Nellie Elizabeth GRABLE First Middle Last		4. DATE OF DEATH Month 6 Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1897
9. AGE (In years last birthday) 64 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Hahn	
14. MOTHER'S MAIDEN NAME Harriett Bostic		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Robert C. Hahn, Greensburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of sigmoid colon with Metastasis 15328 DUE TO (b) 3 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 6, 1961 to June 26, 1961 , that (I) last saw the deceased alive on June 26, 1961 , and that death occurred at P. M. from the causes and on the date stated above			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED June 26, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna. Ave. Hagerstown	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial	23b. DATE THEREOF 6/29/1961	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City, town, or county) (State) Cascade Maryland
24. FUNERAL DIRECTOR'S SIGNATURE S. Marlin Roe		25a. REC'D BY REGISTRAR Waynesboro, Penna.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kiser		DATE JUN 28 '61	

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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7261

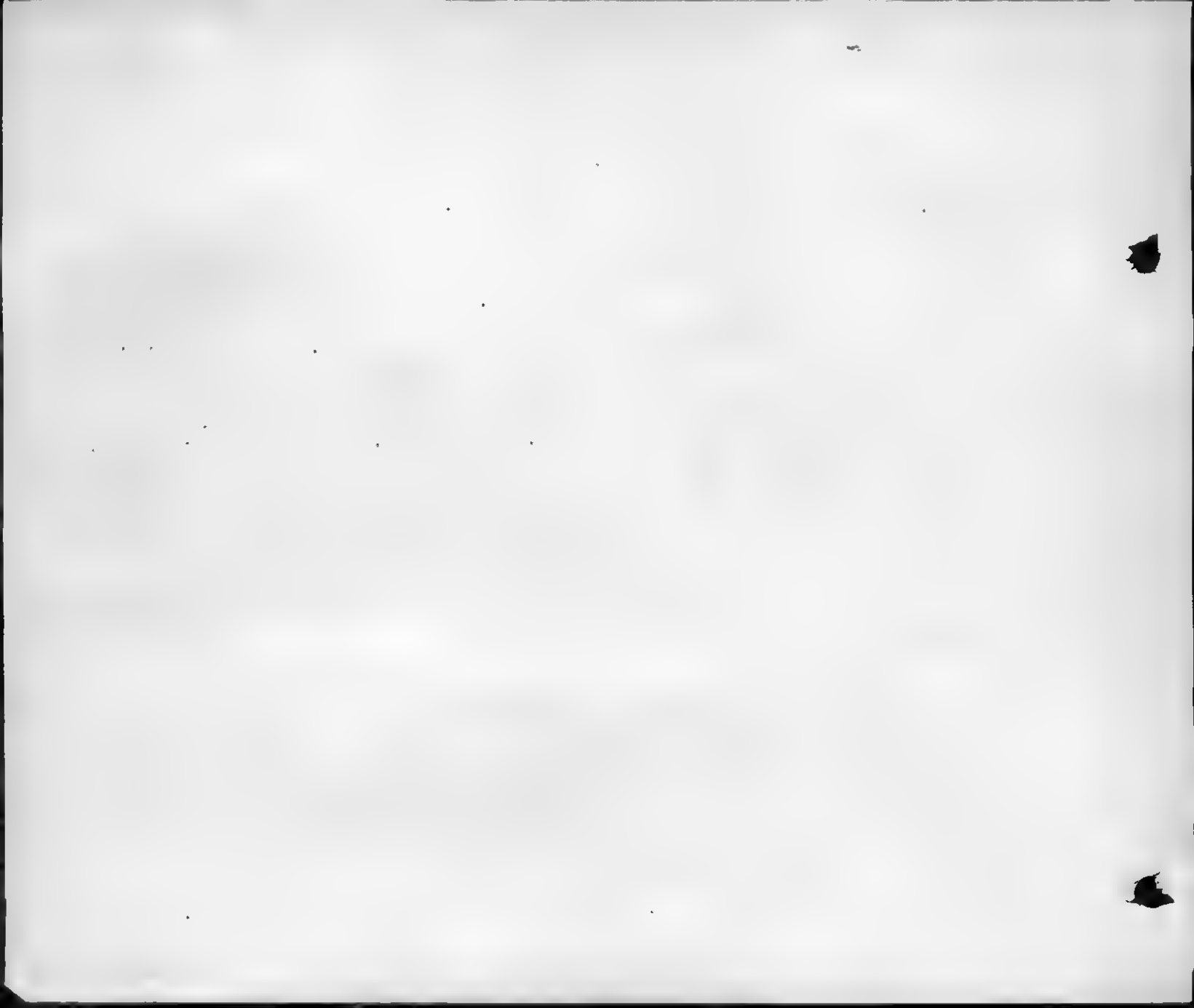
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07250

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>				c. LENGTH OF STAY IN 1b <u>82 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 S. Mechanic Street</u>				e. STREET ADDRESS <u>201 S. Mechanic Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Annetta</u> Middle <u>Moreland</u> Last <u>Gloss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9 1878</u>	9. AGE (In years last birthday) <u>82</u> yrs	IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>	IF UNDER 24 HRS Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>David Gloss</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hagenberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles F. Gross</u> <u>201 S. Mechanic St Sharpsburg Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u></u>	(County) <u></u>	(State) <u></u>		
21. I certify that (I) (this hospital) attended the deceased from <u>5-31-1961</u> to <u>6-6-1961</u> , that (I) (we) last saw the deceased alive on <u>6-6-1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. ADDRESS <u>Boonsboro Md.</u>				
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>			ADDRESS <u>Williamport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 8 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Carl P. Leaf</u>	

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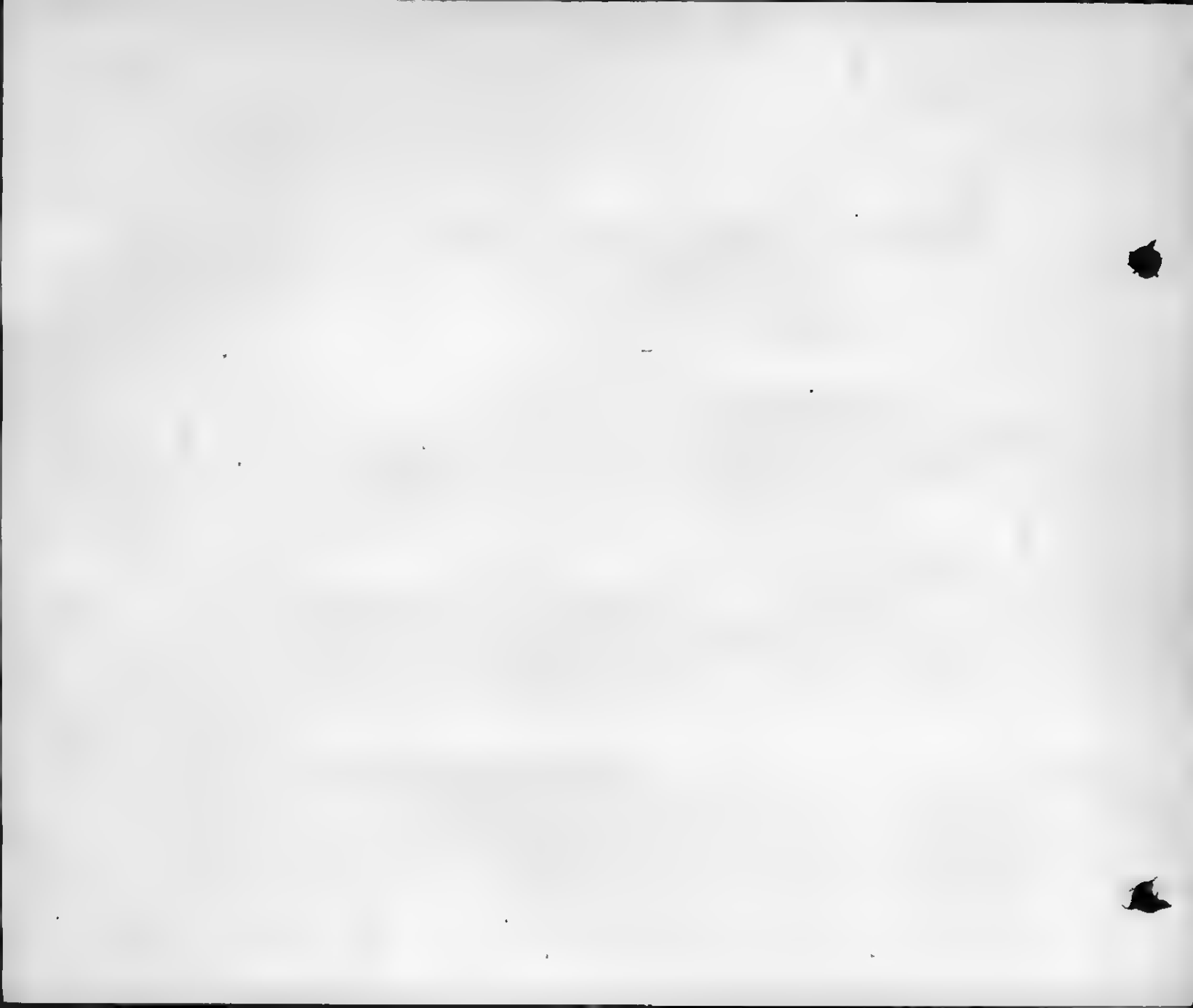


1 **CERTIFICATE OF DEATH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7262

07251

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital		d. STREET ADDRESS 412 Brookline Ave	
3. NAME OF DECEASED (Type or print) Carl First William Middle Guessford Sr CARL WILLIAM S. GUESSFORD		4. DATE OF DEATH Month JUNE Day 26 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 12 1896
9. AGE (n years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 03 Days 03 Hours 03 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver		10b. KIND OF BUSINESS OR INDUSTRY Bester-Long	
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Lee Guessford		14. MOTHER'S MAIDEN NAME Sarah Everhart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-24-8777	
17. INFORMANT Mrs Wilda G. Guessford		Address 412 Brookline Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 141.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Tongue DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Unknown 14 months		INTERVAL BETWEEN ONSET AND DEATH 14 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-26-1961 to 6-26-1961 , that (I) (was) last saw the deceased alive on 6-26-1961 , and that death occurred at 11:29 PM , from the causes and on the date stated above.			
22a. SIGNATURE Antonio U. Pallagrosi		22b. DATE SIGNED June 27, 1961	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI		22d. ADDRESS 1500 PENNA AVE HAGERSTOWN MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/29/61	
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Lem. Gardens		23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR JUN 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



M

7263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07252

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural (Hagerstown)			
c. LENGTH OF STAY IN 1b 1 month				d. STREET ADDRESS R.D.1 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle C. Last Guessford				4. DATE OF DEATH Month June Day 27 Year 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/4/1896	
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor (Retired)		11. BIRTHPLACE (State or foreign country) Potomac Edison Co. Welsh Run, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel J. Guessford				14. MOTHER'S MAIDEN NAME Minerva E. Shaffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 220-10-3993		17. INFORMANT Address Mrs. Harry W. Carbaugh Smithsburg, Md. R.D.2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 10 yrs							INTERVAL BETWEEN ONSET AND DEATH 2 Days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-20-61 19 61 , to 6-26-61 19 61 , that (I) (we) last saw the deceased alive on 5-20-61 19 61 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Charles F. Heer</i>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 6-27-61	
22c. PHYSICIAN'S NAME (Type) Charles F. Heer, M. D.				22d. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/30/61		23c. NAME OF CEMETERY OR CREMATORY Welsh Run Brethern		23d. LOCATION (City, town, or county) (State) Mercersburg Pa. R.D.3 Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Katherine Y. Grove</i>				ADDRESS Waynesboro, Pa.		25a. REC'D BY REGISTRAR DATE III 2 '61	
				25b. REGISTRAR'S SIGNATURE <i>Charles E. Hines</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

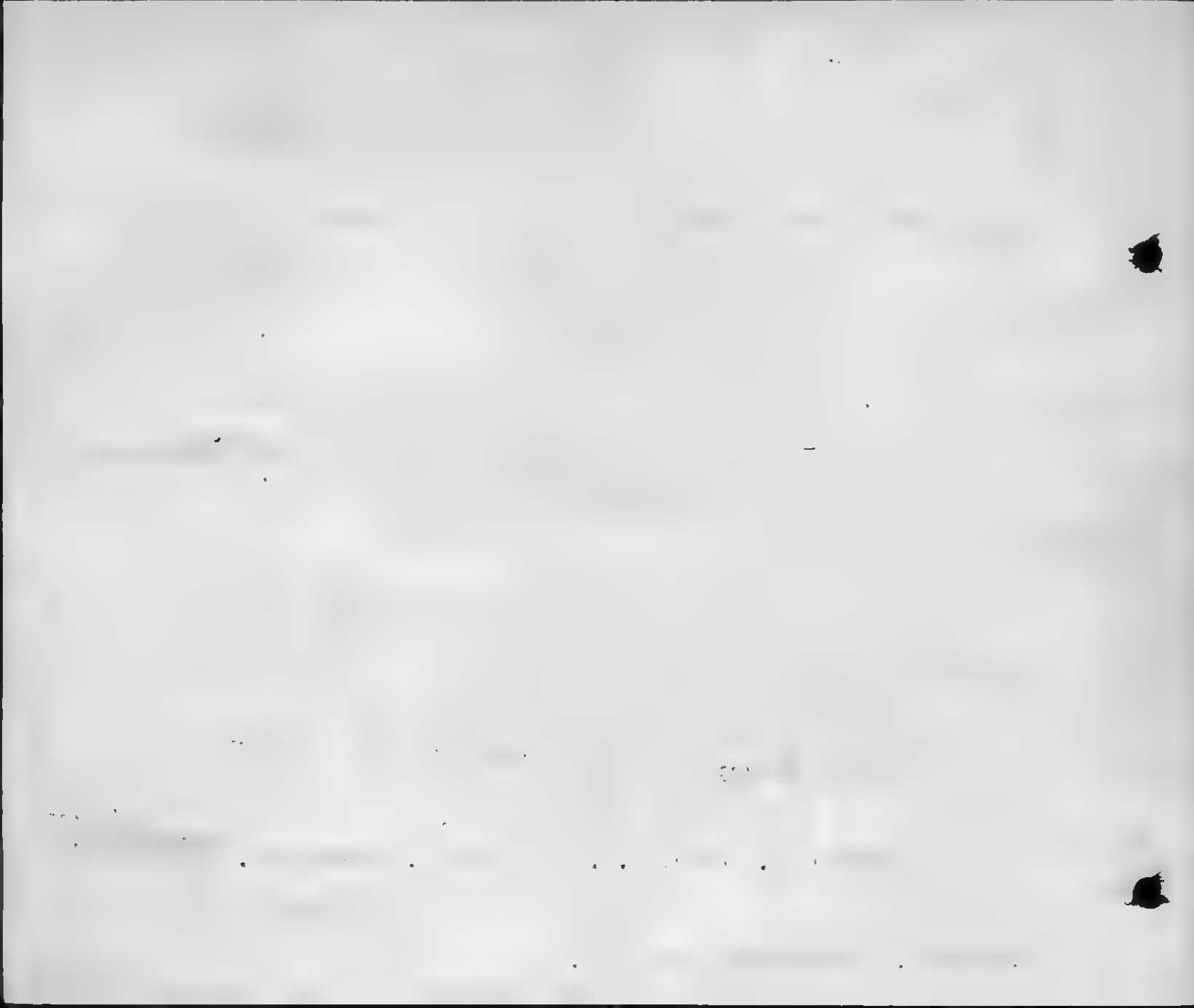
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7264

07253

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>8 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>903 Woodland Way</u>	
3. NAME OF DECEASED (Type or print) <u>JAMES ALLEN HAHN</u>		4. DATE OF DEATH June 12 1961	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 4 1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. AGE (In years) IF UNDER 1 YEAR: Months <u>12</u> Days <u>13</u> IF UNDER 24 HRS.: Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		11. BIRTHPLACE (Country & State, or foreign country) <u>Ind.</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Refrigeration</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James A. Hahn</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Bierley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Mrs. Claude Greager Hahn</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>empyema & congestive failure</u> 1500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arteriosclerosis genl</u> DUE TO (c) <u>1 wk</u> INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>12/19/58</u> , 19 <u>58</u> , to <u>6/12/61</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/6/61</u> , 19 <u>61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Howard N. Weeks, M.D.</u>		22b. DATE SIGNED <u>6/14/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22d. ADDRESS <u>136 N. Potomac St., Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/15/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co. Ind.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>JUN 19 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>			



7265

CERTIFICATE OF DEATH

Reg. Dist. No. 07254

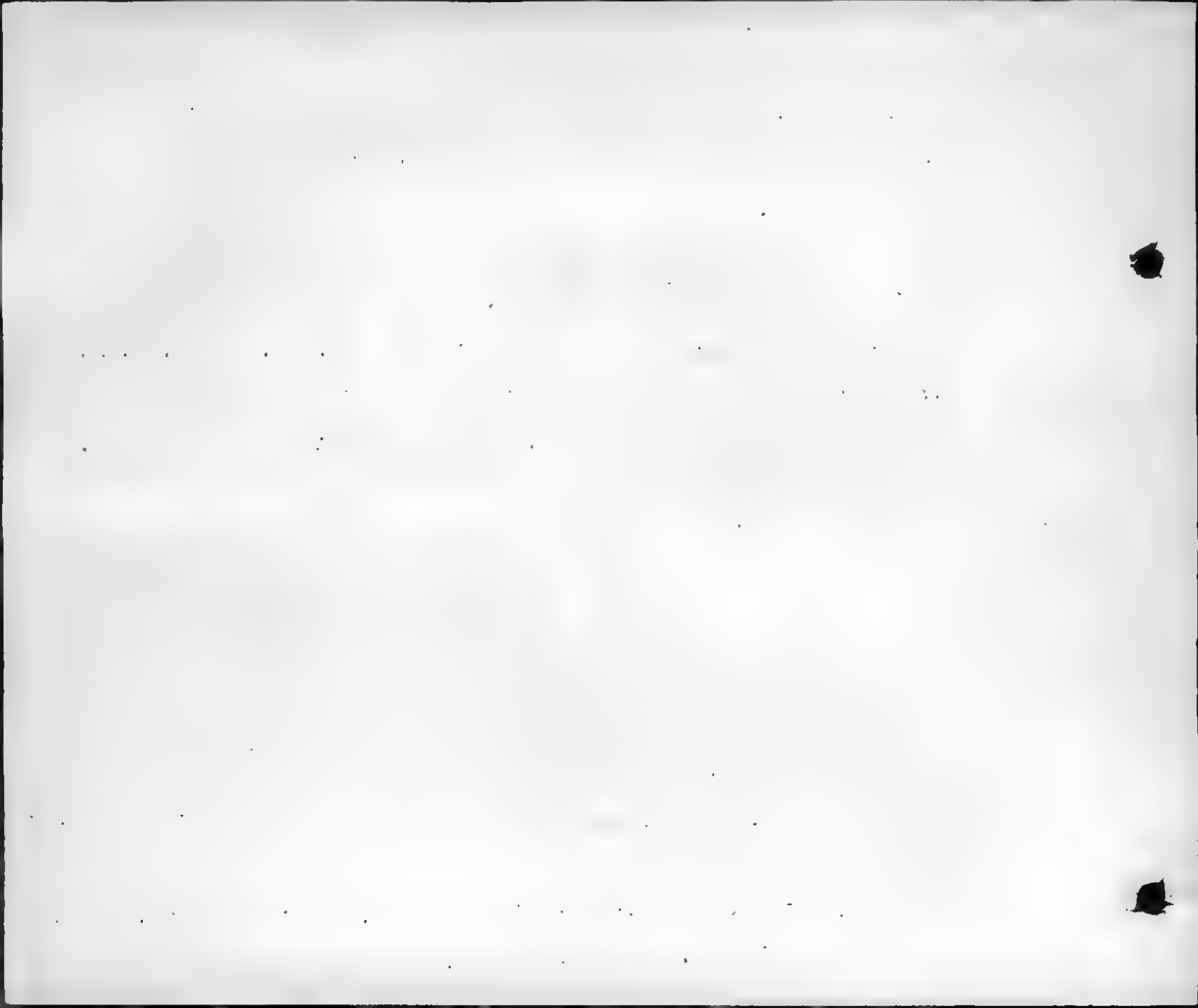
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Myersville	
		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) First MATTIE Middle SUSAN Last HARSHMAN		4. DATE OF DEATH Month June Day 9 Year 1961	
5 SEX female	6 COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1893
9 AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Cyrus Blickenstaff		14. MOTHER'S MAIDEN NAME Flora Palmer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
INFORMANT J. Frank Harshman, Myersville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CVD. DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 5 yrs. 5 yrs.	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15 , 19 56 , to 6-9 , 19 61 , that I last saw the deceased alive on 6-9 , 19 61 , and that death occurred at 7:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hoss M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Smithsburg Md. 6-10-61	
PHYSICIAN'S NAME (Type) Charles F. Hoss			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial June 12, 1961		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Grossnickle's		22d. LOCATION (City, town, or county) (State) Nr. Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Myersville, Md.	
24a. REC'D BY REGISTRAR JUN 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Hoss	

Page 4 hours after death.

The low requires that the death certificate be executed within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death.

VS A15 (4)
15M 9/58



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

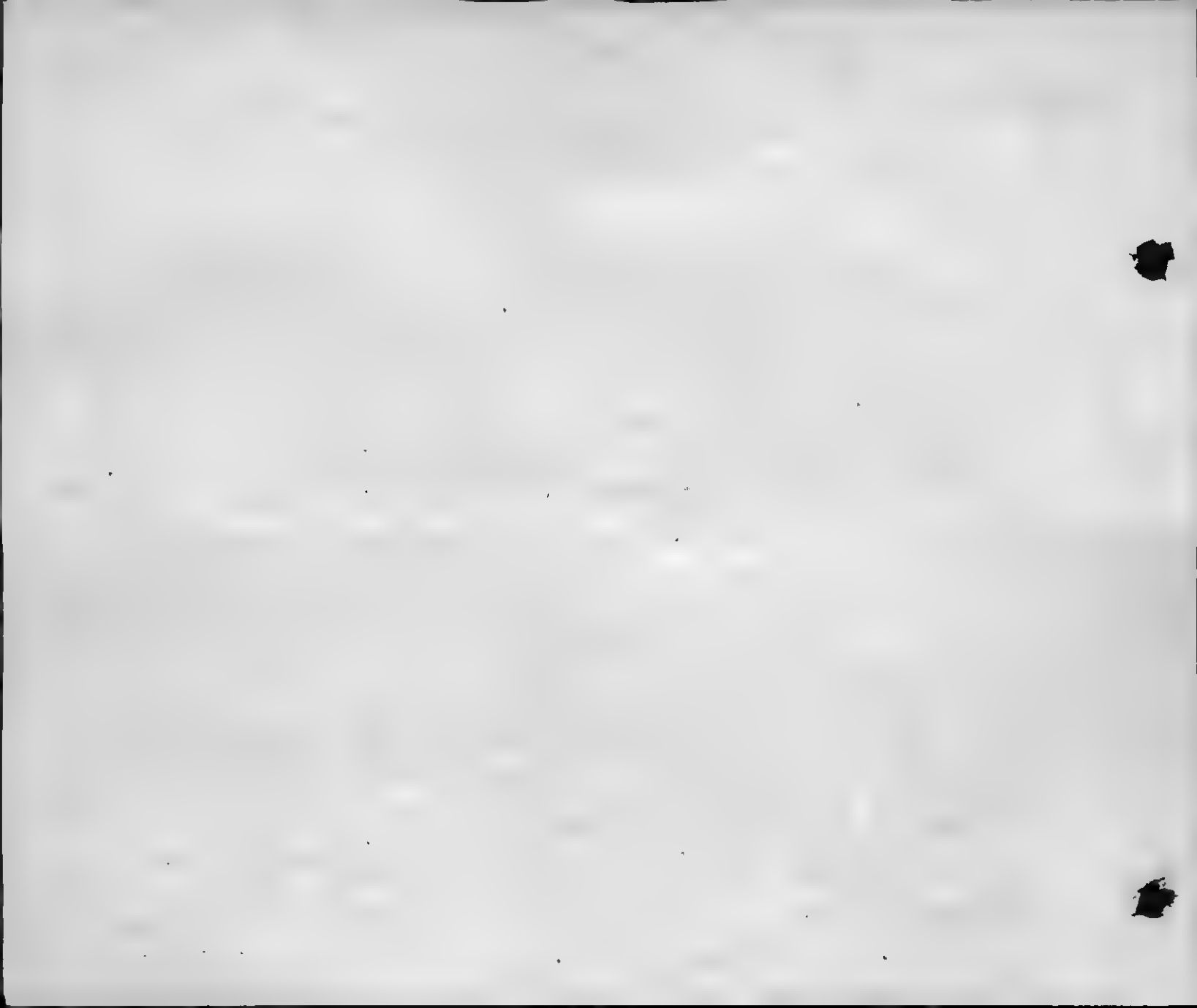
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7263

07255

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>2 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1708 Crest Drive</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1708 Crest Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH HYDE HEALEY</u> f. SEX <u>Female</u> g. COLOR OR RACE <u>White</u> h. MARIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> i. DATE OF BIRTH <u>Nov. 6 1872</u> j. AGE (In years last birthday) <u>88</u> yrs. k. IF UNDER 1 YEAR Months <u>17</u> Days <u>19</u> l. IF UNDER 24 HRS. Hours <u>12</u> Min. <u>45</u>		4. DATE OF DEATH <u>June 17 1961</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Halifax England</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William H. Hyde</u> 14. MOTHER'S MAIDEN NAME <u>Mary Harris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mrs Ernestine H. Marvin</u> Address <u>1708 Crest Drive Hagerstown</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Heart Disease</u> (c) <u>14 yr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12 hr</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> 20f. (City or town) <u>Hagerstown</u> (County) <u>Washington</u> (State) <u>Md</u>		21. I certify that (I) (his hospital) attended the deceased from <u>Feb 17 1961</u> to <u>June 17 1961</u> , that (I) (we) last saw the deceased alive on <u>Feb 17 1961</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Joseph A. Hoffman</u> 22c. PHYSICIAN'S NAME (Type) <u>J. A. Hoffman</u>		22b. DATE SIGNED <u>June 17 1961</u> 22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md</u>	
23a. BURIAL, CREMATION, 123b. DATE THEREOF <u>Burial 6/17/61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Beechwood Cemetery</u> 23d. LOCATION (City, town or county) <u>Ottawa Ontario Canada</u> (State) <u>Canada</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u> 25a. REC'D BY REGISTRAR <u>JUN 20 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	



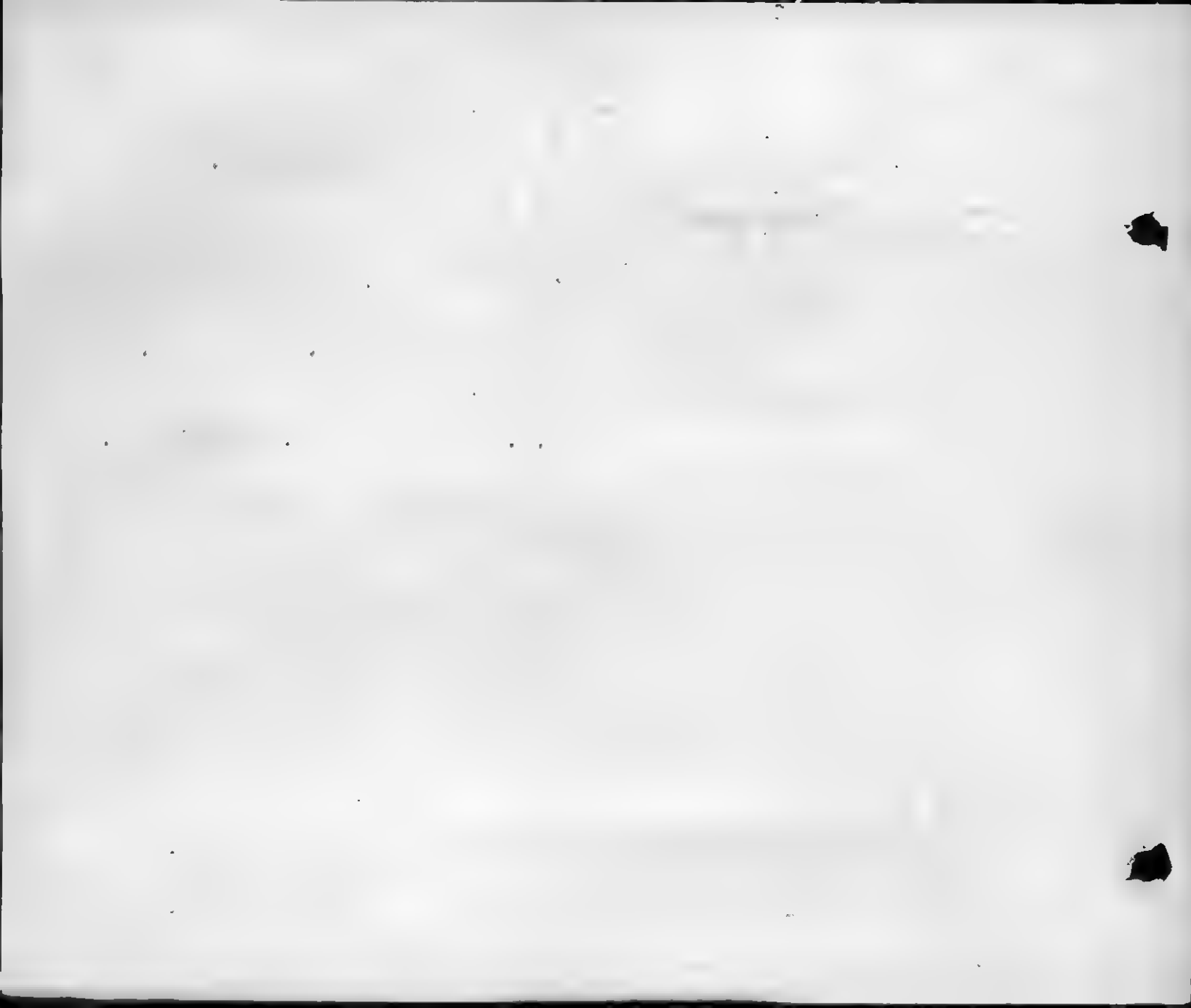
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

7267

7 & CERTIFICATE OF DEATH

67256

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN 1b 60yrs d. NAME OF HOSPITAL (if not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Paul Last Hopkins		4. DATE OF DEATH Month June Day 8 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 22 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Private family	11. BIRTHPLACE (State or foreign country) Big Pool Md.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Henry Hopkins	
14. MOTHER'S MAIDEN NAME Katherine William		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Address T.A. William 313 N. Potomac St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Esophagus DUE TO (b) Arteriosclerosis general DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. INTERVAL BETWEEN ONSET AND DEATH ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 26 1961 to June 8 1961 , that (I) (we) lost saw the deceased alive on June 8 1961 , and that death occurred at 6:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 6-10-1961	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
24. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr Hagerstown Md.		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		25c. DATE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

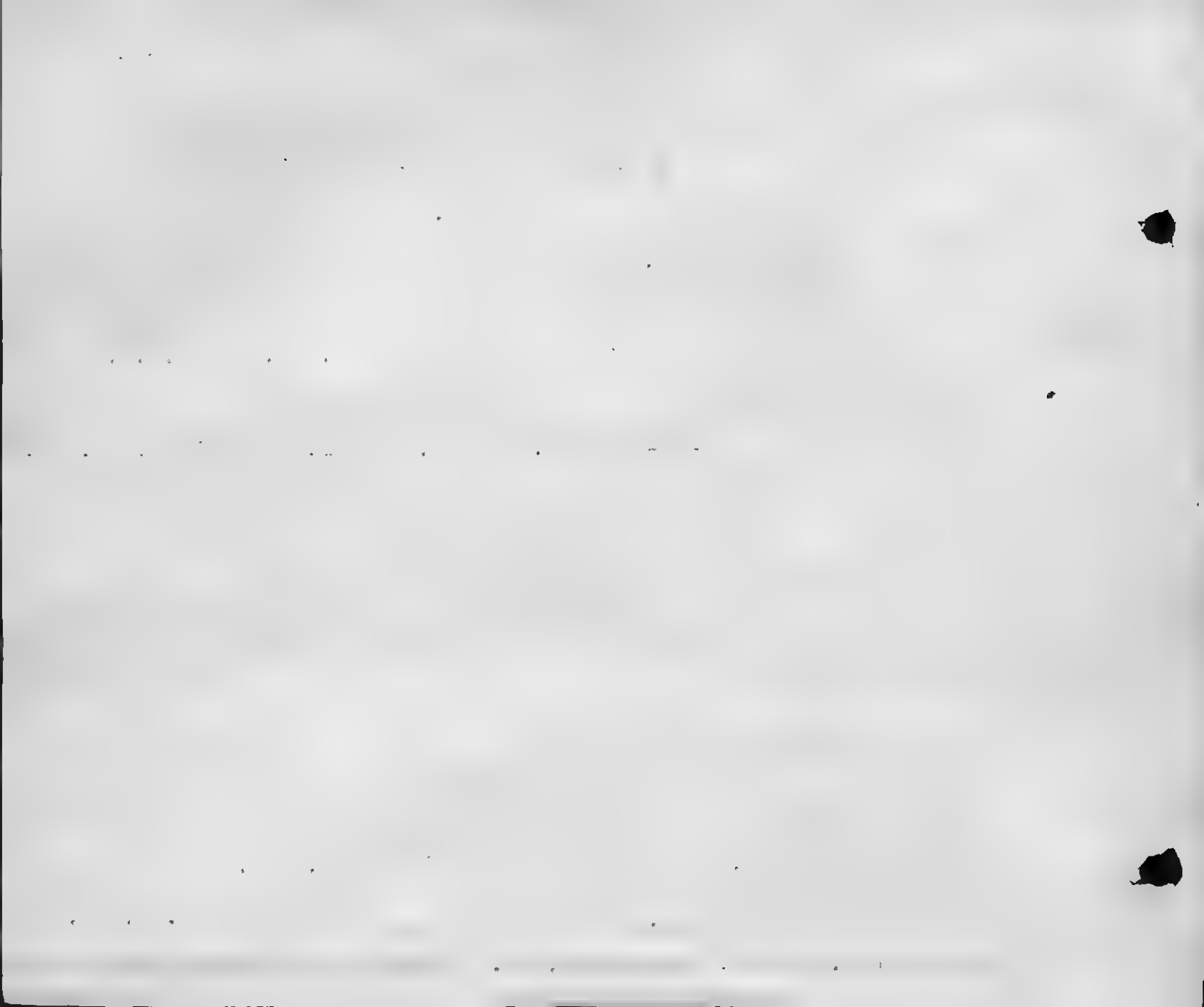
CERTIFICATE OF DEATH

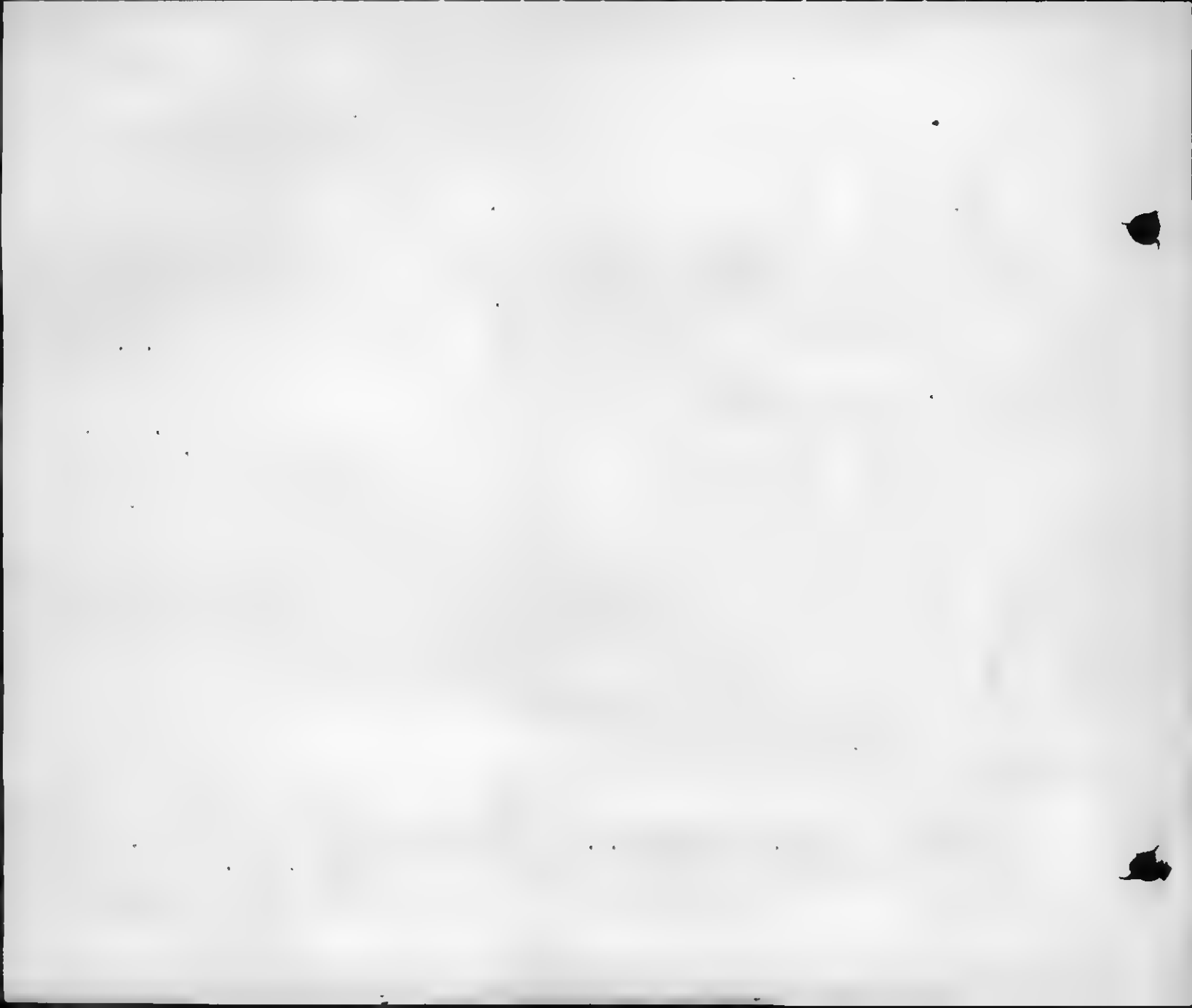
7269

07257

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>5 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Memorial Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Myersville</u> d. STREET ADDRESS <u>Rt. # 1 Wolfsville</u> a. 15. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ASBURY E. HOOVER</u>		4. DATE OF DEATH <u>June 13 19 61</u>	
5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>March 7, 1876</u> 9. AGE (in years last birthday) <u>85</u> yrs. 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> 11. IF UNDER 24 HRS. Hours <u> </u> Mins. <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own gen farm</u>		13. FATHER'S NAME <u>John Jacob Hoover</u> 14. MOTHER'S MAIDEN NAME <u>Sarah Ann Kline</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>219-36-4449</u> 17. INFORMANT <u>Mrs. Mary J. Hoover, Myersville, Md.</u> Address <u>Rt. #</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>422.1</u>	
18. CAUSE OF DEATH (continued) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>		20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>		21. I certify that (I) (this hospital) attended the deceased from <u>10-30-57</u> 19 <u>57</u> to <u>6-13-61</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>6-13-61</u> 19 <u>61</u> and that death occurred at <u>10:45 AM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Charles F. Hess</u> 22b. DATE SIGNED <u>6-14-61</u> 22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS <u>Smithsburg Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> 23b. DATE THEREOF <u>June 16, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Lutheran</u> 23d. LOCATION (City, town or county) <u>Wolfsville, Fred. Co. Md.</u> (State) <u> </u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u> 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u> DATE <u>JUN 20 '61</u>	

TO HO...AL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07253**

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 338 N. Cannon Ave.,				d. STREET ADDRESS 338 N. Cannon Ave.,			
3. NAME OF DECEASED (Type or print) <div style="display: flex; justify-content: space-around;"> First Roy Middle Scott Last Hoover </div>				4. DATE OF DEATH <div style="display: flex; justify-content: space-around;"> Month 6 Day 29 Year 19 61 </div>			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH Sept. 7, 1881		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Fiddlersburg, Md.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Columbus Hoover			
14. MOTHER'S MAIDEN NAME Laura Ellen Rohrer				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 220-05-6827		17. INFORMANT Address Miss May G. Hoover Hagerstown, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex;"> <div style="flex: 1;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4x0.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="flex: 2;"> Arterio Sclerotic Heart Dis. </div> <div style="flex: 0.5; border-left: 1px solid black; padding-left: 5px;"> INTERVAL BETWEEN ONSET AND DEATH 2 days </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PR. MARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 			
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/>. Inquiry <input type="checkbox"/>. and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE J. E. W. [Signature]		EXAMINER'S NAME (Type) J. E. W. [Signature]		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-3-61		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
22d. LOCATION (City, town, or county) (State) Hagerstown Md.		23. FUNERAL DIRECTOR'S SIGNATURE Kraiss Funeral Home Hagerstown, Md.					
24a. REC'D BY REGISTRAR DATE JUL 3 '61		24b. REGISTRAR'S SIGNATURE [Signature]					

TO DIE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

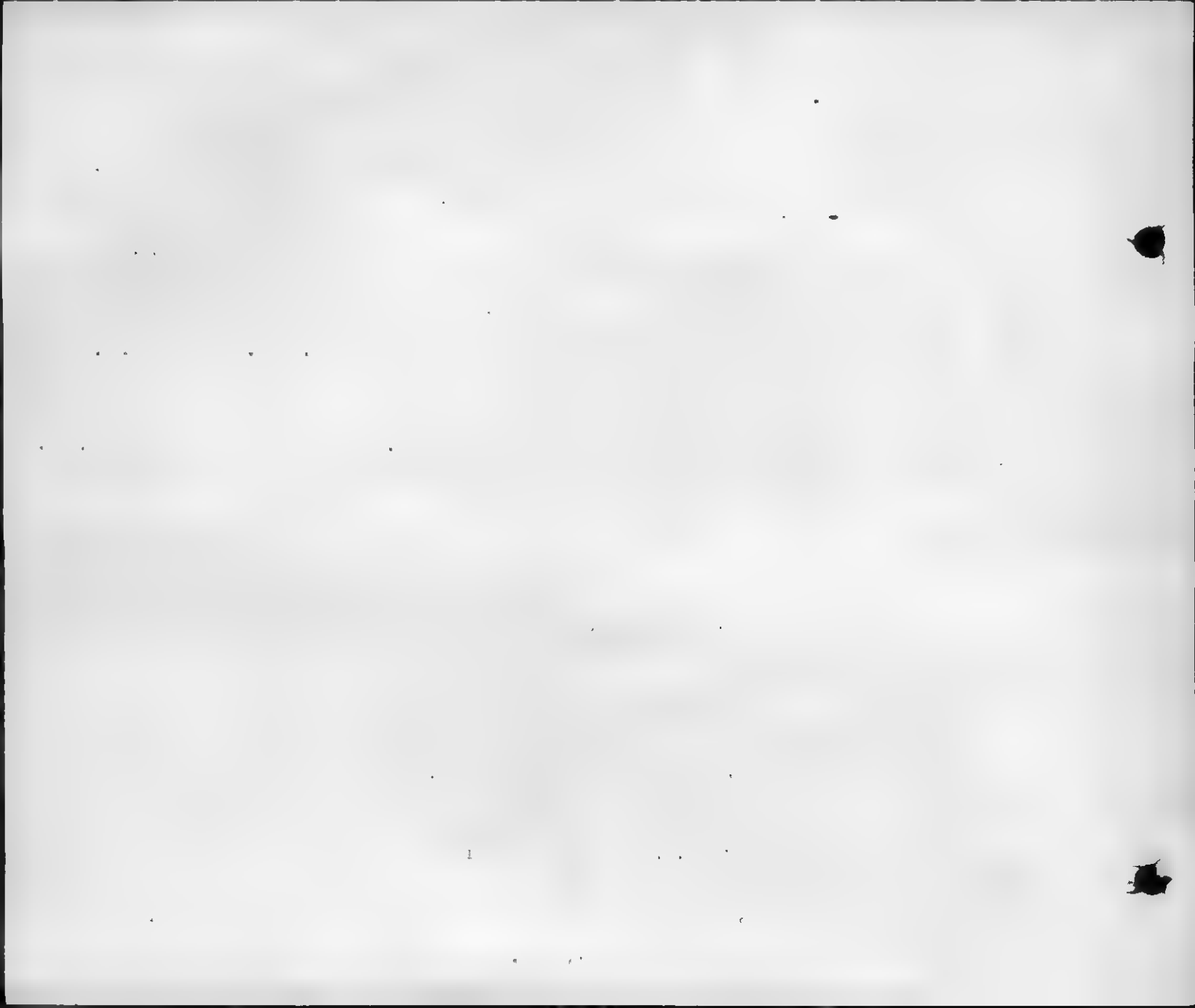


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7271		Items 5, 6 & 7 Film 9289 6/23/61		07260	
1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 1 WEEK d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		MARYLAND		USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELSIE PRUDENCE HORNBAKER		First Middle Last		4. DATE OF DEATH JUNE 14 19 61	
5 SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8 DATE OF BIRTH AUG. 25, 1892		9 AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		11. BIRTHPLACE (State or foreign country) FRANKLIN CO. PA.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MARTIN DRURY		14. MOTHER'S MAIDEN NAME ELLIE BRITTON	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM L. HORNBAKER, CLSPG. MD. RD. 1	
18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CALCAREOUS AORTIC STENOSIS 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) March 28 1958 to June 14 1961	
21 I certify that (I) (the undersigned) attended the deceased from June 13, 1961 , and that death occurred 4:30 AM from the causes and on the date stated above		22a. SIGNATURE Archie Robert Cohen, M.D.		22b. DATE SIGNED 6/15/61	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland		25a. REC'D BY REGISTRAR JUN 19 61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 17, 1961		23c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEMETERY	
23d. LOCAL ON (City, town, or county) SHANKTOWN, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Brand		25c. REGISTRAR'S ADDRESS CLEAR SPRING, MD.	

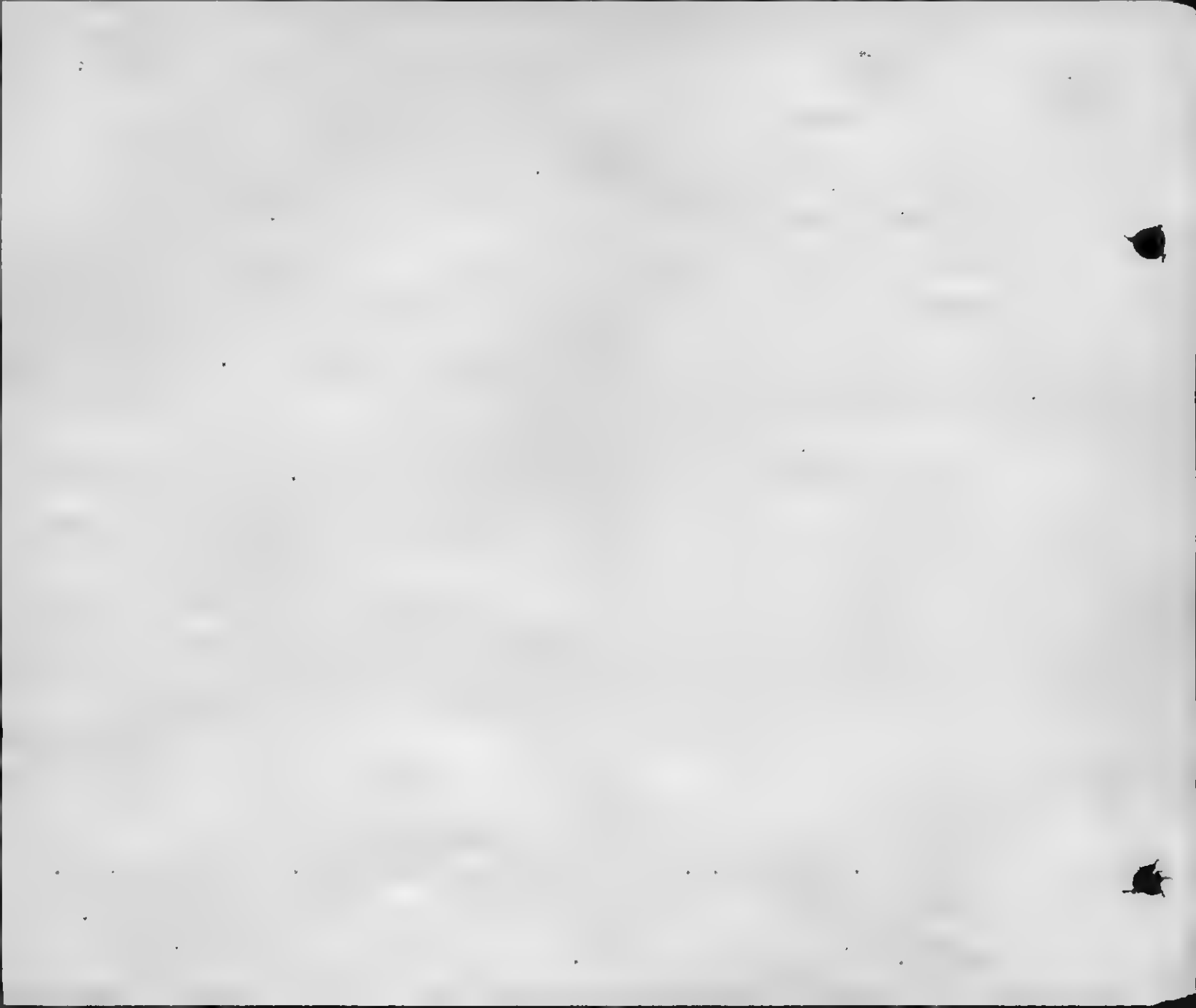


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7272											
07261											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>1 1/2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Martin Manor</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>620 Potomac Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>MOLLIE MIDDLEKAUFF HOWARD</u>						4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>1961</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>white</u>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>March 16 1876</u>					
9. AGE (In years last birthday) <u>85</u> yrs.						10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>					
11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown Wash Co Md.</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Joseph Middlekauff</u>						14. MOTHER'S MAIDEN NAME <u>Ann Horine</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Claytor Howard</u>						Address <u>1222 Virginia Ave Hagerstown Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the liver</u> 400-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>with Congestive Cardiac Failure</u> (c) <u>2 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1946</u> to <u>6-23</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-23</u> , 19 <u>61</u> , and that death occurred <u>6:45 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Dalton M. Welty</u> M.D.						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>Dalton M. Welty, M.D.</u>						22d. ADDRESS <u>998 Potomac Ave., Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>						23b. DATE THEREOF <u>6/26/61</u>					
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>						23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>						25a. REC'D BY REGISTRAR <u>June 27 '61</u>					
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											



FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

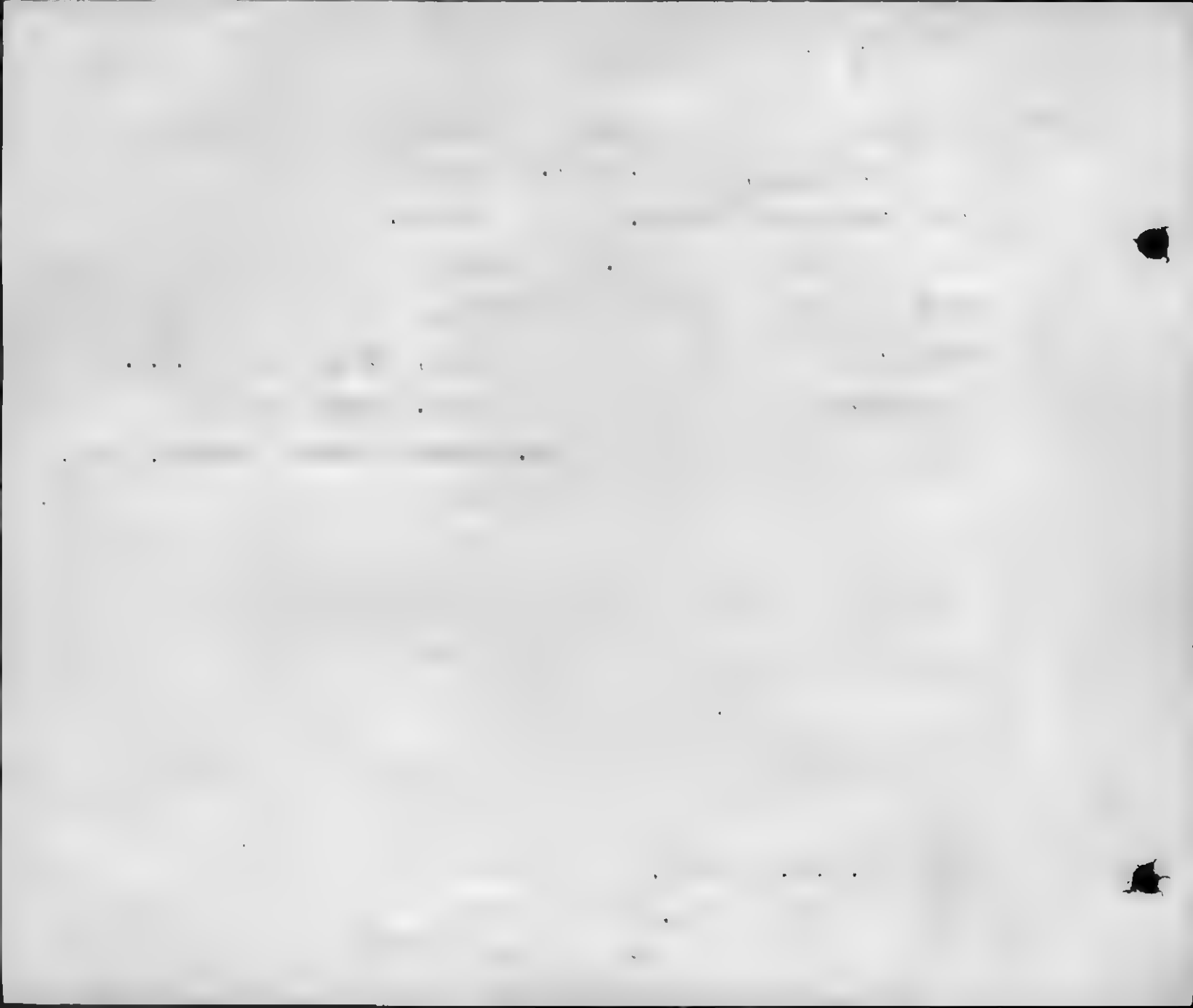
VS. A TIME
SM 7/59

7273
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07262

<p>1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural Clearman Spring</u> c. LENGTH OF STAY IN 1b <u>1 Yr. 11 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Gateway Convalescent Home Inc.</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if instit on: Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hancock</u> d. STREET ADDRESS <u>Main St.</u></p>				<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>									
<p>3. NAME OF DECEASED (Type or print) <u>Effie S. Hughes</u></p>		<p>4. DATE OF DEATH <u>6 3 19 61</u> Month Day Year</p>		<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>9/9/1887</u></p>		<p>9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months <u>3</u> Days <u>19</u> IF UNDER 24 HRS.: Hours <u>61</u> Min.</p>					
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>				<p>11. BIRTHPLACE (State or foreign country) <u>Addison, Pennsylvania</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>					
<p>13. FATHER'S NAME <u>William Stark</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Ella F. Tishue</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>Mrs. Margaret Coleman</u> Address <u>Pittsburg, Penna.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis, Severe</u> 4X DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Marked Cerebral Arteriosclerosis</u></p>														<p>INTERVAL BETWEEN ONSET AND DEATH <u>Several years.</u></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>														<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>													
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) _____ (County) _____ (State) _____</p>									
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>																	
<p>ACTUAL SIGNATURE <u>[Signature]</u></p>				<p>EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u></p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>				<p>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>		<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/></p>		<p>DATE SIGNED <u>6-5-61</u></p>	
<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>22b. DATE THEREOF <u>6/7/61</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u></p>				<p>22d. LOCATION (City, town, or country) <u>Hancock</u> (State) <u>Maryland</u></p>							
<p>23. FUNERAL DIRECTOR <u>Kathleen M. Grose</u></p>				<p>ADDRESS <u>Hancock Md.</u></p>				<p>24a. REC'D BY REGISTRAR <u>JUN 9 '61</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>[Signature]</u></p>							

MEDICAL CERTIFICATION



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7274

07263

1 PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ASTERN MD. STATE HOSPITAL		d. STREET ADDRESS 807 SALEM AVE.	
3 NAME OF DECEASED (Type or print) First Ruth Middle Viola Last KENDALL		4. DATE OF DEATH Month 6 Day 3 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 3, 1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 5 Days 3 Hours 1 Min.	11. IF UNDER 24 HRS. Months 5 Days 3 Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY T. MOATS		14. MOTHER'S MAIDEN NAME BESSIE MILLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-14-7431	
17. INFORMANT MRS. MAE KOONTZ		Address RT 2 GREENCASTLE, PENNA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung DUE TO (c) 5 months		INTERVAL BETWEEN ONSET AND DEATH One week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1961 to June 3, 1961 that (I) was last saw the deceased alive on June 3, 1961 and that death occurred at 3:47 M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED June 3, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 6, 1961	
23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG		23d. LOCATION (City, town, or county) (State) WASHINGTON COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. GRAISS		ADDRESS HAGERSTOWN, MD.	
25a. REC'D BY REGISTRAR DATE JUN 6 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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C7264

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07265

7276

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R. F. D. #4</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest Milburn Kirby</u>				4. DATE OF DEATH Month <u>June</u> Day <u>4</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18 1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>16</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water Plant Operator</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Berkeley Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>James William Kirby</u>		14. MOTHER'S MAIDEN NAME <u>Ella Barrow</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 01 9972</u>		17. INFORMANT <u>Mrs. Helen E. Kirby</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u> DUE TO (b) <u>Prostatic Carcinoma</u> DUE TO (c) <u> </u>	
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>none</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u> <u>18 mos</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>1961</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 1960</u> to <u>6-4</u> , 19 <u>61</u> , that (1) (we) last saw the deceased alive on <u>6-3</u> , 19 <u>61</u> , and that death occurred at <u>6-4</u> , 19 <u>61</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Byrkit</u>				22b. DATE SIGNED <u>6-5-61</u>		22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Wolf Williamsport, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



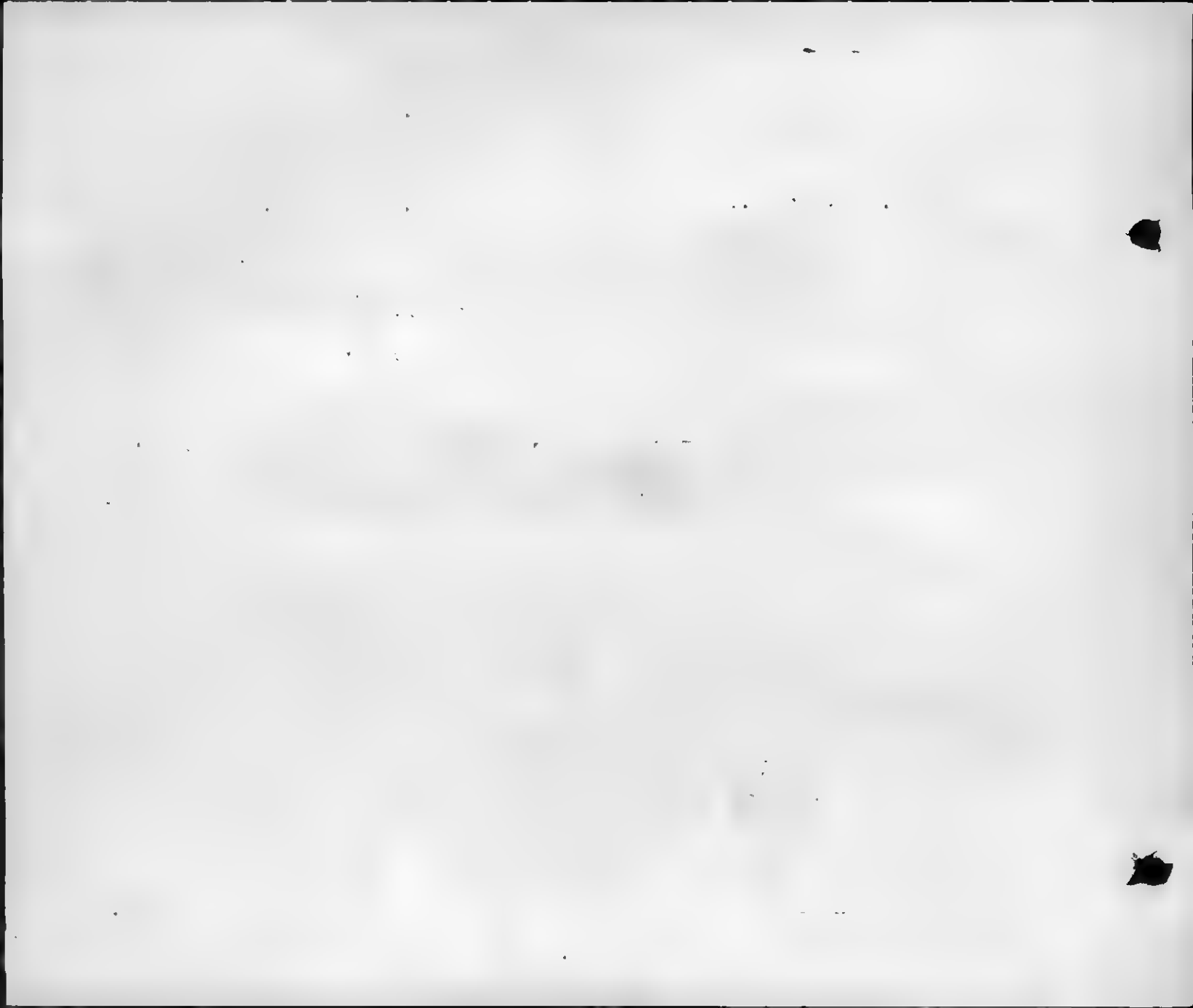
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07266

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 49 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 N. Potomac St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Kraiss				4. DATE OF DEATH Month 6 Day 12 Year 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 19-1873	
9. AGE (In years last birthday) 87 yrs		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director				10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Tioga, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Paul Kraiss				14. MOTHER'S MAIDEN NAME Helen Harer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 219-36-2711		17. INFORMANT Mrs. Margaret Kraiss Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.0 DUE TO arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4-1-61 19 to 6-12-61 19, that (I) (we) last saw the deceased alive on 6-12-61 19, and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE A. E. W. J. T. T. O. J. M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>							
22c. PHYSICIAN'S NAME (Type) A. E. W. J. T. T. O. J. 22d. ADDRESS Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6-15-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kraiss Funeral Home				25a. REC'D BY REGISTRAR JUN 16 '61		25b. REGISTRAR'S SIGNATURE Carlton S. Kraiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

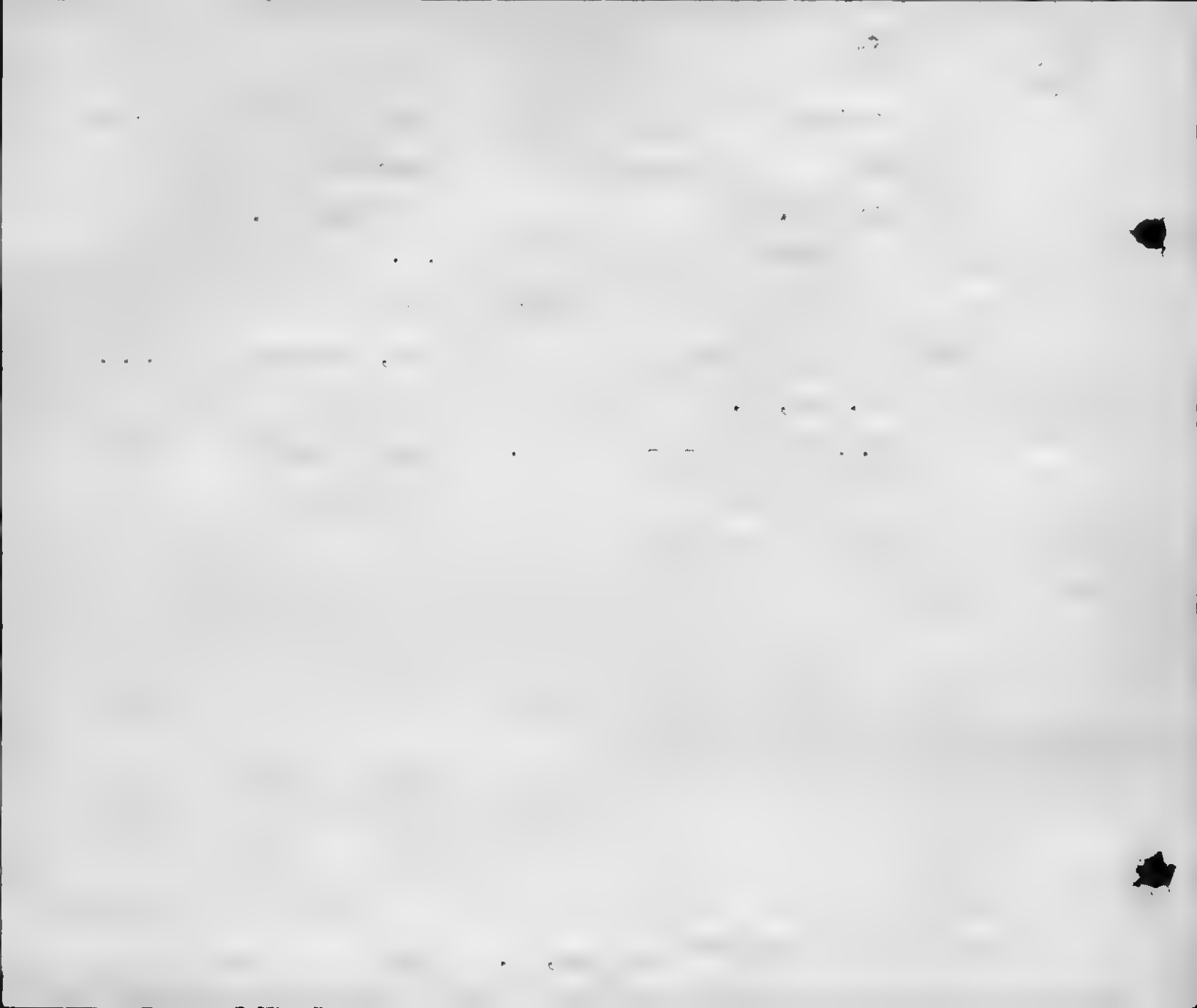
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07267

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b. 28 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 656 Virginia Ave.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 656 Virginia Ave.	
3. NAME OF DECEASED (Type or print) JOHN MELCAJAH LACY, JR.		4. DATE OF DEATH Month June Day 22 Year 1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1907	
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months 3 Days 1 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager		10b. KIND OF BUSINESS OR INDUSTRY shoe store	
11. BIRTHPLACE (County & State or foreign country) Scottsburg, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John M. Lacy, Sr.		14. MOTHER'S MAIDEN NAME Emaline Priest	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. II		16. SOCIAL SECURITY NO. 214-09-0372	
17. INFORMANT Mrs. Ruth Lacy		Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 202.1 DUE TO metastatic lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 202.1 DUE TO metastatic lymphoma PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 10 p.m. 11		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown (County) Md. (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/11/58 , to 10/22/61 , that (I) (we) last saw the deceased alive on 6/21/61 , and that death occurred at 4:30 M, from the causes and on the date stated above.			
22a. SIGNATURE Robert V. H. Campbell M.D.		22b. DATE SIGNED 9/22/61	
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Peyer		25a. REC'D BY REGISTRAR JUN 28 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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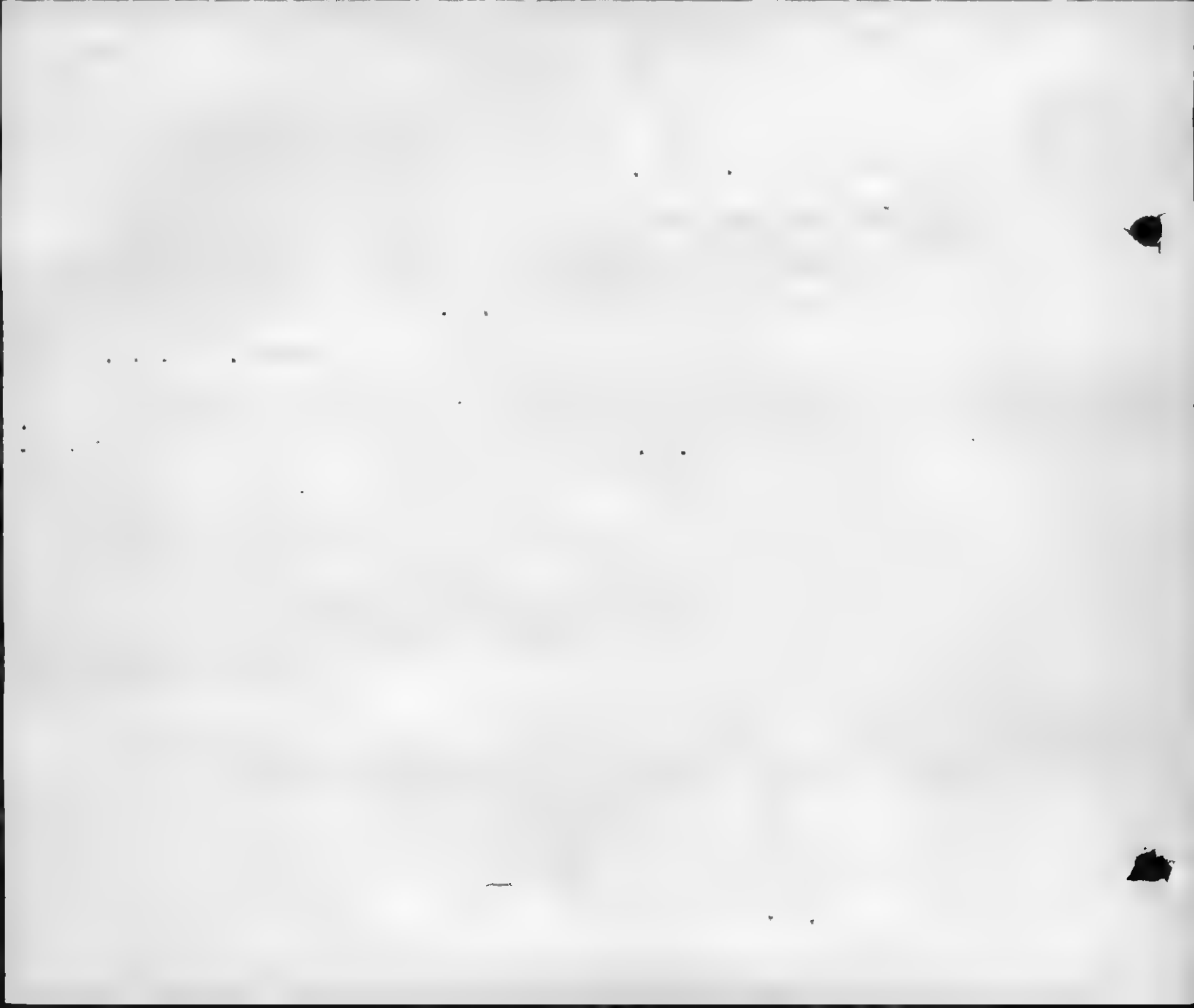
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

C7268

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown Md.				c. LENGTH OF STAY IN 1b 1 Mo. 5 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gate Way Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Aaron Middle Henderson Last Lanehart				4. DATE OF DEATH Month 6 Day 26 Year 1961			
5. SEX M	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 20, 1878		9. AGE (In years last birthday) yrs 83	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Issac Lanehart				14. MOTHER'S MAIDEN NAME Savannah Younker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 204.01.5368		17. INFORMANT Preston E Lanehart Address Hagerstown Md. 2001 Lexington Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure DUE TO Chronic Valvular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 3 yrs. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 20, 1961 to June 26, 1961 , that (I) (we) last saw the deceased alive on June 26, 1961 , and that death occurred at 5:30 P.M. from the causes and on the date stated above							
22a. SIGNATURE David R. Brewer				22b. DATE 6/27/61		22c. PHYSICIAN'S NAME (Type) David R. Brewer	
22d. ADDRESS Clear Spring Md.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 6/27/61	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 6.29.61		23c. NAME OF CEMETERY OR CREMATORIAL Park Head		23d. LOCATION (City, town, or county) (State) Rural Hancock Washington Md	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Stone				25a. REC'D BY REGISTRAR DATE JUN 29 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7280

C7269

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admiss on) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willow Hill, Pa.</u>	
c. LENGTH OF STAY IN TB <u>D.O.A.</u>		d. STREET ADDRESS <u>7280</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary</u>	First <u>Mary</u> Middle <u>E</u> Last <u>Lehman</u>	4. DATE OF DEATH	Month <u>June</u> Day <u>28</u> Year <u>1961</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18 1902</u>
9. AGE (In years last birthday) <u>59</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maugansville Wash. Co. Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>David Martin</u>	14. MOTHER'S MAIDEN NAME <u>Mary Horst</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Howard F. Lehman</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction?</u> <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>1 day</u> DUE TO (c) <u>years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>27 JUNE</u> 19 <u>61</u> , to <u>28 JUNE</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>27 JUNE</u> 19 <u>61</u> , and that death occurred at <u>.....</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard T. Binford</u> M.D.	ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>30 June 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard Binford</u> M.D.	22d. ADDRESS <u>1135 POTOMAC AVENUE, HAGERSTOWN, MARYLAND</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/1/1960</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Chambersburg Mennonite</u>	23d. LOCATION (City, town or county) (State) <u>Chambersburg, Pa.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Chas. M. Rouser - Fox</u>		25a. REC'D BY REGISTRAR <u>Chambersburg, Pa.</u>	
25b. REGISTRAR'S SIGNATURE <u>Shelley Ann Home</u>		DATE <u>AUG 3 '61</u>	

TO REGISTERING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

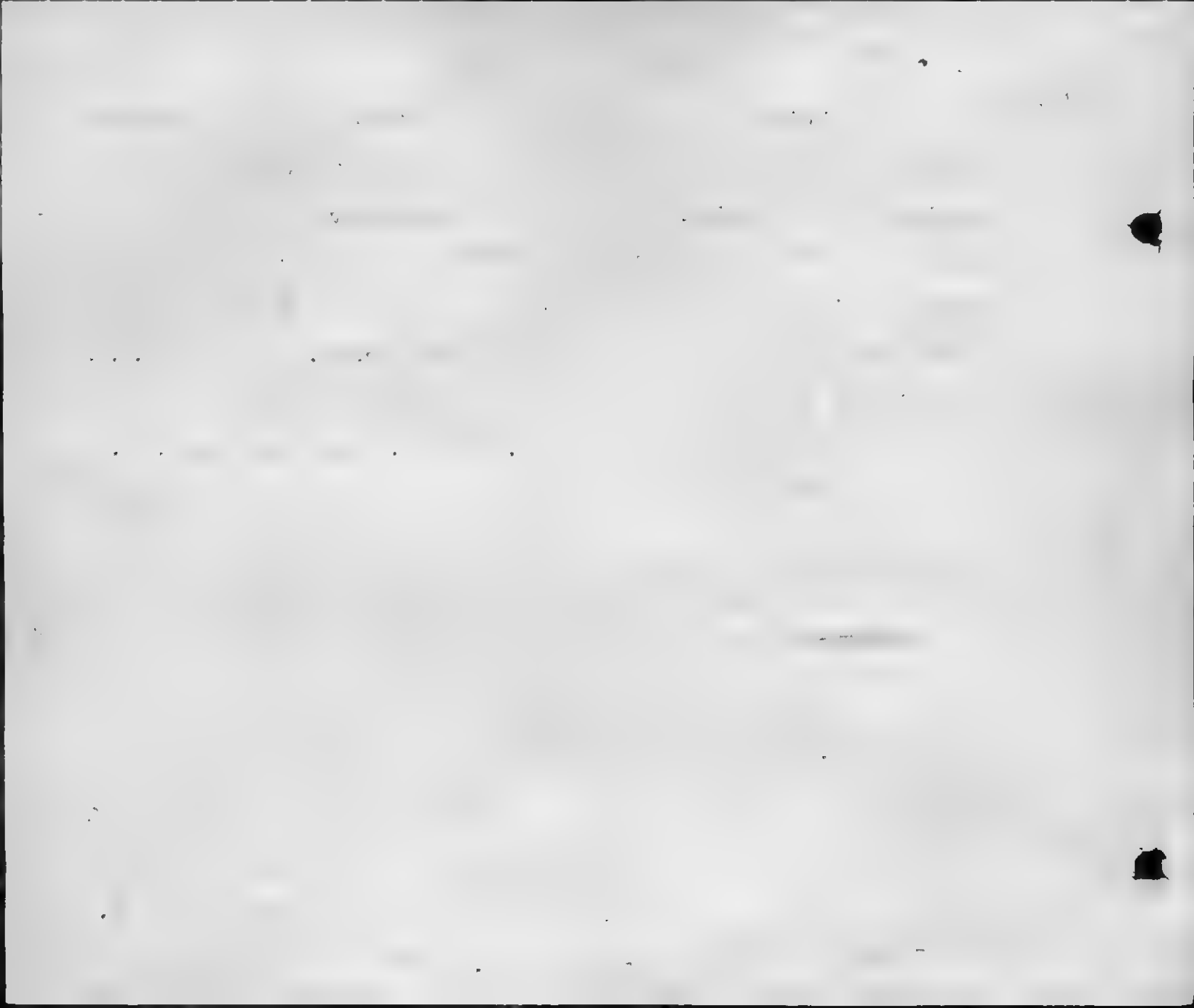
CERTIFICATE OF DEATH

07270

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN TB Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown (Rural) d. STREET ADDRESS Avalon Manor e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED [Type or print] GRACE CANNON First Middle Last		4. DATE OF DEATH June 7 1961 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 27, 1879 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 81 IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTH-PLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Clay Loose		14. MOTHER'S MAIDEN NAME Virginia Pearson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO	
17. INFORMANT Mrs. Victor D. Miller		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis DUE TO Conditions, if any, which gave rise to immediate cause (b) 7 days (c), stating the underlying cause last DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio-sclerotic Hypertensive vascular disease			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1, 1961 to June 7, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above			
22a. SIGNATURE Lloyd A. Hoffman M.D.		22b. DATE SIGNED 6/8/61	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/9/1961	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown Md.
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home <i>Franklin Suter</i>		25. REC'D BY REGISTRAR DATE JUN 12 '61 Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

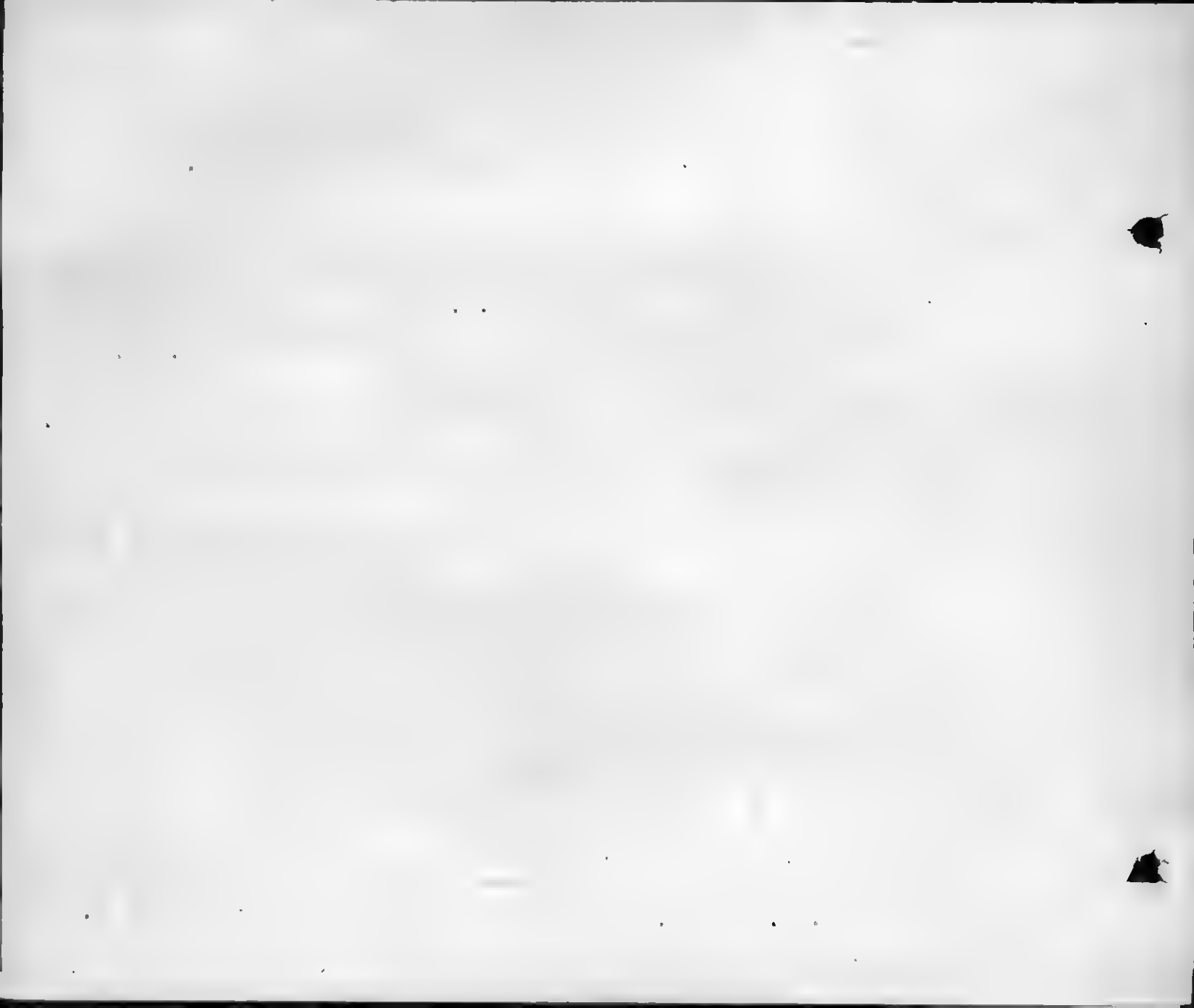
7282

07271

Item 6 from 5290 7/30/61 ink

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 5 Hagerstown Md.</u>	
c. LENGTH OF STAY IN 1b <u>6 Months</u>		d. STREET ADDRESS <u>Western Chronic Hospital</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Thomas</u> Last <u>MACCUMBEE</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1918</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernon E MacCumbsee</u>		14. MOTHER'S MAIDEN NAME <u>Vergie M Van Gosen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Vernon E MacCumbsee</u>		Address <u>Rural 5 Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> 196-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ewing's Sarcoma with Metastasis</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1961</u> to <u>June 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1961</u> , and that death occurred at <u>7:55</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D.		22b. DATE <u>June 23, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6.26.61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peter's Catholic</u>		23d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Stone</u>		25a. REC'D BY REGISTRAR <u>Hancock Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>		DATE <u>JUN 28 '61</u>	

I



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 4 hours after death. If any fee is necessary, please enclose it with this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

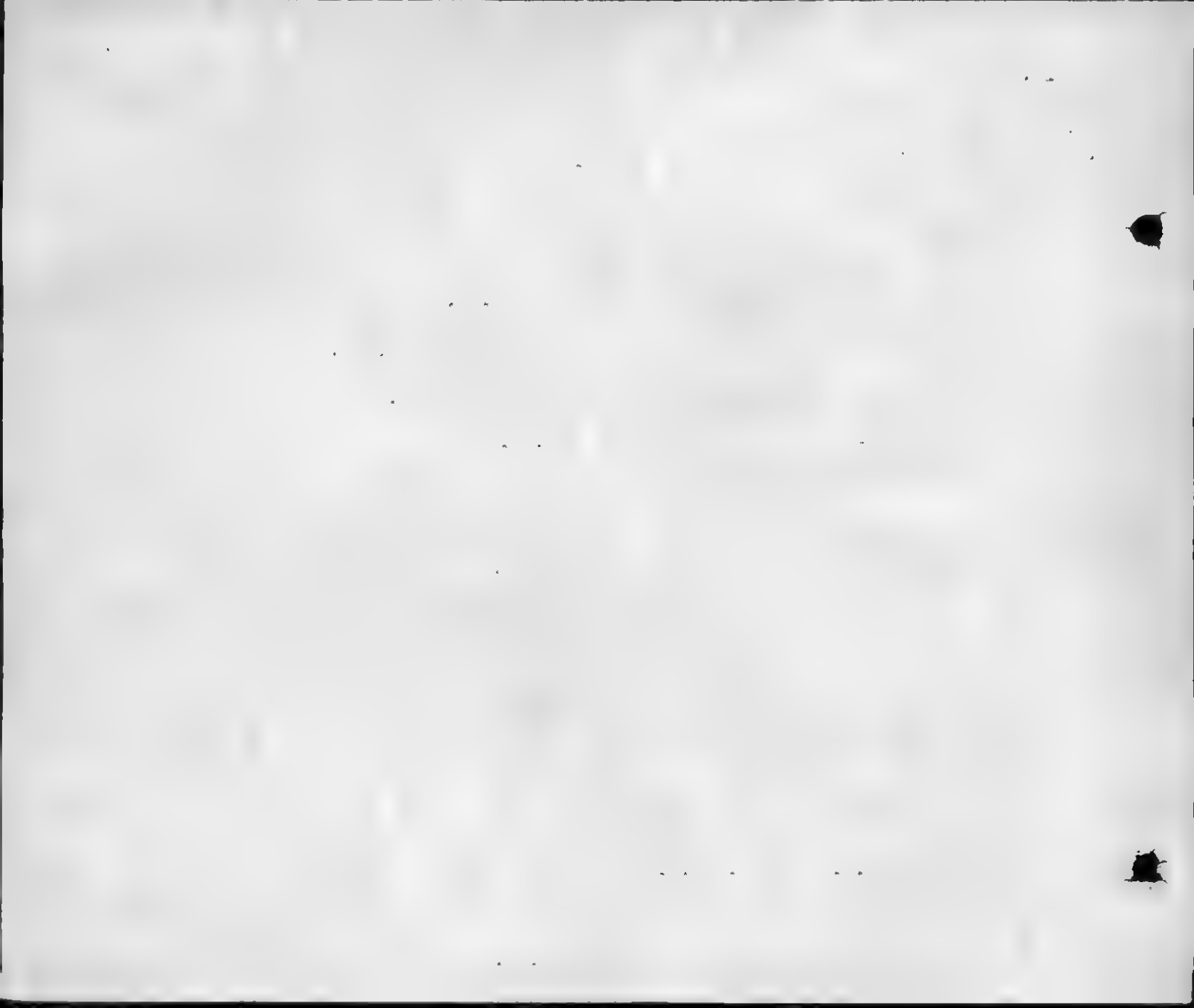
VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07272

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route # 4 Hagerstown</u> c. LENGTH OF STAY IN 1b <u>16 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 4</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Route # 4 Hagerstown</u> d. STREET ADDRESS <u>Route # 4</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Oliver</u> Last <u>Marquiss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 27, 1894</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pine County, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Abraska Marquiss</u>				14. MOTHER'S MAIDEN NAME <u>Sadie E. White</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>351-07-0528</u>		17. INFORMANT <u>E. E. Marquiss</u>		Address <u>Hagerstown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>191-3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Involving the Right Temporal &</u> DUE TO <u>Maxillary Area Of Face.</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>3 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. W. Ditto Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>6-23-61</u>	
EXAMINER'S NAME (Type) <u>E. W. Ditto Jr. M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/26/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) <u>Hagerstown</u>		(State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> <u>Wm. G. Horst</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 23 1961</u>		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7284

07273

1. PLACE OF DEATH a. COUNTY <u>Wash. T. N.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville, md.</u>			
c. LENGTH OF STAY IN 1b <u>5 Days</u>				d. STREET ADDRESS <u>Maugansville, md</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>S.</u> Last <u>MARTIN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/1915</u>	9. AGE (In years last birthday) <u>45</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POULTRY FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Co, md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel MARTIN</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-12-0709</u>		17. INFORMANT <u>Mrs. Bertha Martin</u> Address <u>Maugansville, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5/28, 1961</u> to <u>6/3, 1961</u> , that (I) (we) last saw the deceased alive on <u>6/3 1961</u> , and that death occurred <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John H. Hornbaker</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-5-61</u>				
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>		22d. ADDRESS <u>154 West Washington St., Hagerstown, Md.</u>					
23a. BURIAL OR CREMATION, REMOVED (Specify) <u>B</u>	23b. DATE THEREOF <u>6/6/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>	23d. LOCATION (City, town, or county) (State) <u>Cearfoss, Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.C. Minnick</u>		ADDRESS <u>Greencastle Pa.</u>	25a. REC'D BY REGISTRAR DATE <u>JUN 8 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Robert L. Tinsley</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death. The law requires that the death certificate be executed within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

31
7285
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07274

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN MD. <u>19 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 North Locust Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>111 North Locust Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WILLIAM FERLAN McBRIDE</u>		4. DATE OF DEATH <u>June 2 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 27, 1876</u> 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor W. RR. Railroad</u>		9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Western Maryland Mineral Co. W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Colum McBride</u>		14. MOTHER'S MAIDEN NAME <u>Mary V. Ullrich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-10-7249</u>	
17. INFORMANT <u>Ira W. McBride</u> Address <u>Cumberland, Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occluding infarction</u> 400.0 DUE TO <u>Arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (b) <u>3 days + years</u> (c) <u>Intestinal obstruction probable. Bundle branch block.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1952</u> to <u>2 June 1961</u> , that (I) (we) last saw the deceased alive on <u>1 June 1961</u> , and that death occurred at <u>11:00 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard T. Binford</u>		22b. DATE SIGNED <u>2 JUNE, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD L. BINFORD, M. D.</u>		22d. ADDRESS <u>1125 POTOMAC AVENUE, HAGERSTOWN, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/4/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Wash. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>June 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Andrew K. Coffman</u>			

1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of the names of the members of the committee who have been elected to the office of the Secretary.

3. The third part of the document is a list of the names of the members of the committee who have been elected to the office of the Treasurer.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7286

07275

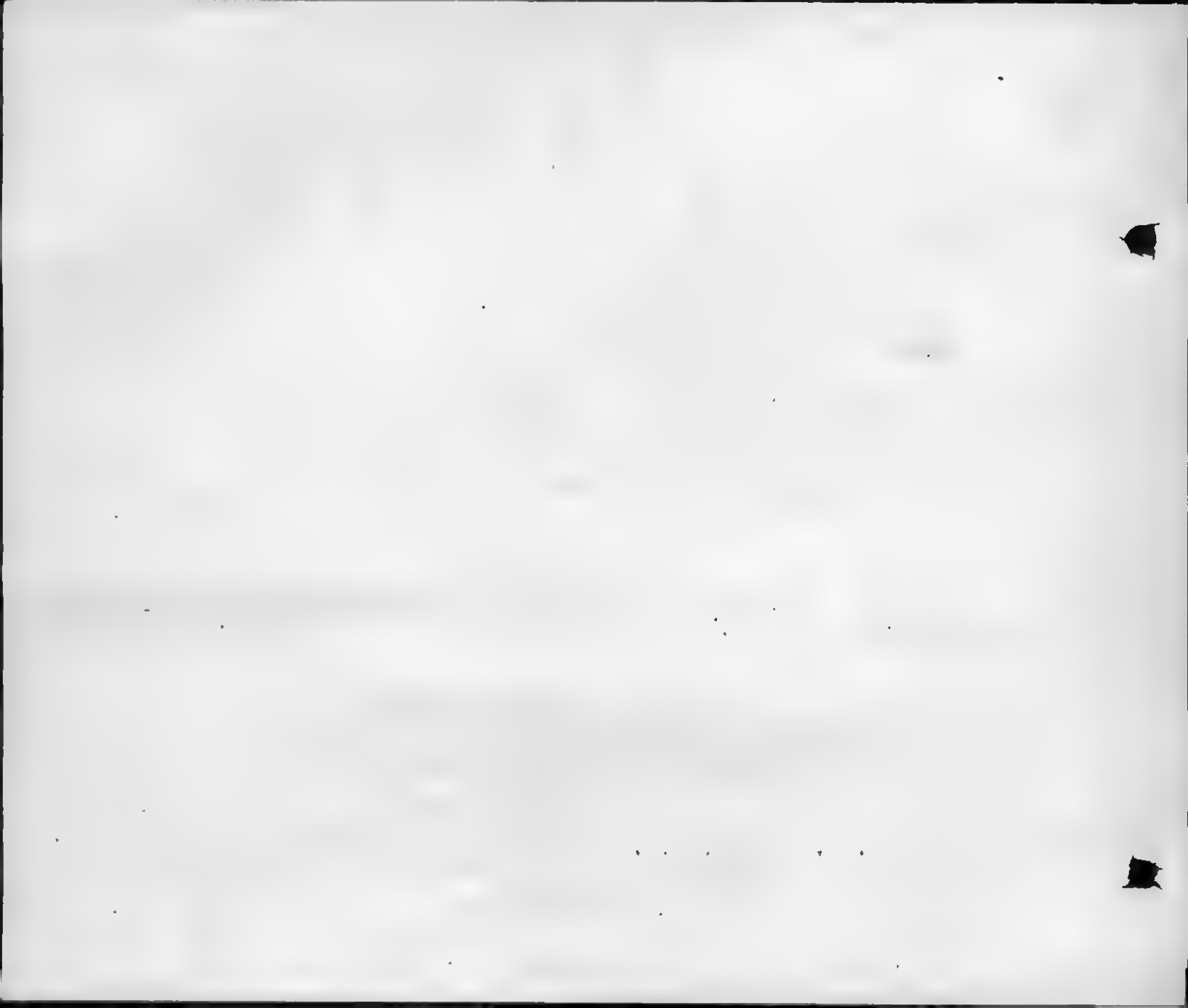
1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Res dence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 17 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Louise Mentzer		4. DATE OF DEATH Month Day Year June 21 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1913
9. AGE (In years last birthday) yrs 47		10. IF UNDER 1 YEAR Months Days Hours Min 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planner		10b. KIND OF BUSINESS OR INDUSTRY Aircraft	
11. BIRTHPLACE (State or foreign country) Lovettsville, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Franklin P. Mentzer		14. MOTHER'S MAIDEN NAME Ida Grams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 215-20-9013		16. SOCIAL SECURITY NO. Miss Virgie E. Mentzer Hagerstown, Md	
17. INFORMANT Miss Virgie E. Mentzer Hagerstown, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Brain Abscess DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Diabetes Mellitus. Arteriosclerotic and Hypertensive Cardiovascular Disease. Intracapillary glomerulonephritis. INTERVAL BETWEEN ONSET AND DEATH Indeterminate.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) W. T. Layman, M.D. attended the deceased from June 7 1961 to June 21 1961 , that (I) (Xe) last saw the deceased alive on June 21 1961 , and that death occurred at 11:35a from the causes and on the date stated above.			
22a. SIGNATURE W. T. Layman, M.D.		22b. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Lovettsville, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR JUN 26 1961	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Charles S. Hanna	

M

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MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

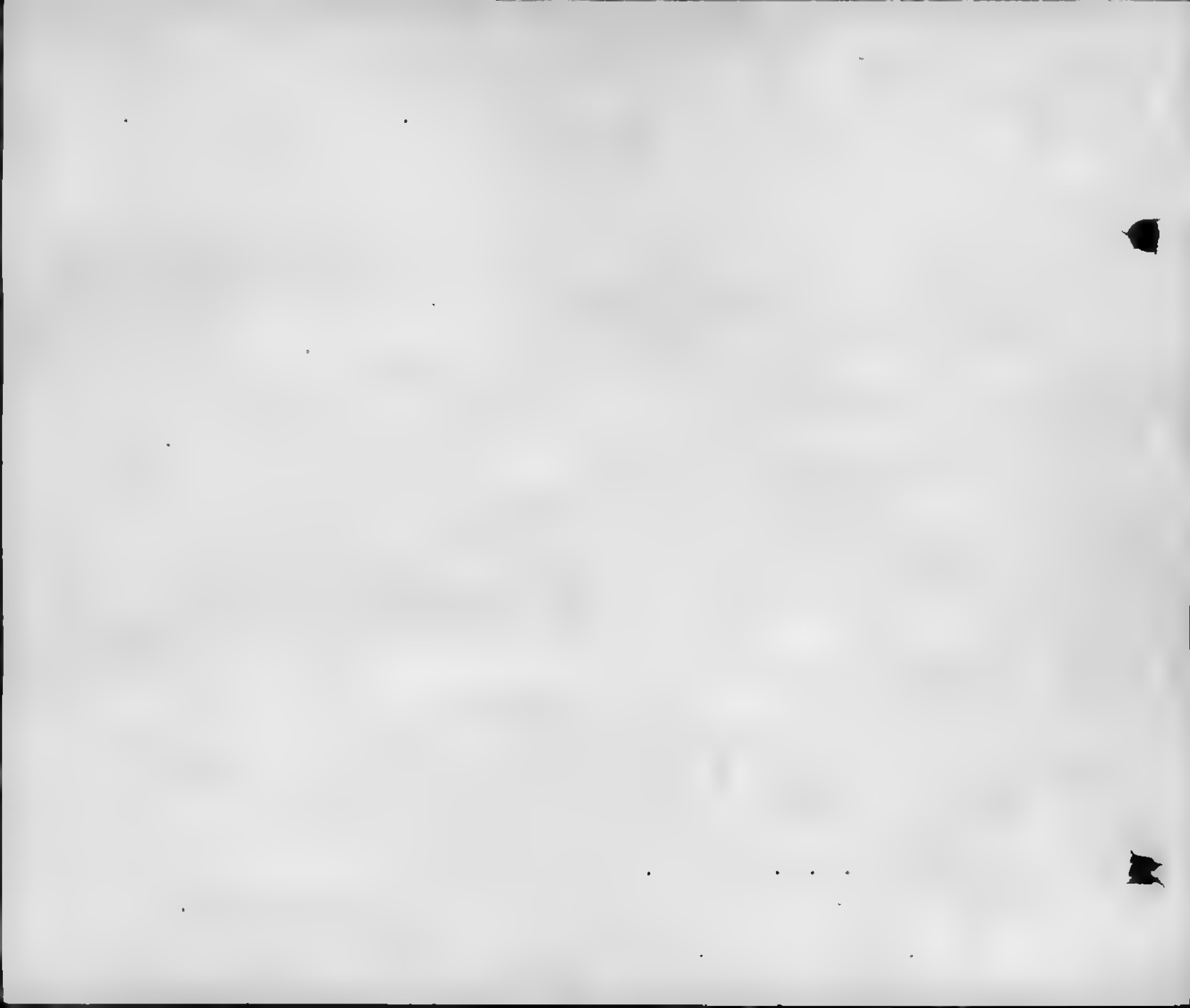
TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY		Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE		Md.	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town)		Funkstown		c. LENGTH OF STAY IN 1b		3 1/2 months		b. COUNTY	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS		Funkstown		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
3. NAME OF DECEASED (Type or print)		Carrie		Eva		Miller		4. DATE OF DEATH Month Day Year	
5. SEX		female		6. COLOR OR RACE		white		June 4, 19 61	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		June 11, 1909		9. AGE (In years, est birthday) yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		domestic		10b. KIND OF BUSINESS OR INDUSTRY		house work		11. BIRTHPLACE (State or foreign country)	
						Smithsburg, Md.		12. CITIZEN OF WHAT COUNTRY?	
								USA	
13. FATHER'S NAME		Albert Reynolds		14. MOTHER'S MAIDEN NAME		Lula Kendall			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		no		16. SOCIAL SECURITY NO.				17. INFORMANT Address Elmore Miller, Funkstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.0		DUE TO		Arteriosclerotic Heart Disease	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)				DUE TO			
		(c)						INTERVAL BETWEEN ONSET AND DEATH Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Dr. J. J. Datto, Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		Dr. J. J. Datto, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)		DATE SIGNED 6-6-61	
22a. BURIAL, CREMATION, REMOVAL (Specify)		burial		22b. DATE THEREOF		6-7-61		22c. NAME OF CEMETERY OR CREMATORY	
								Rose Hill Cemetery	
								Hagerstown, Md.	
23. FUNERAL DIRECTOR		Scott F. Minnich & Son, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
						DATE JUN 8 '61		Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

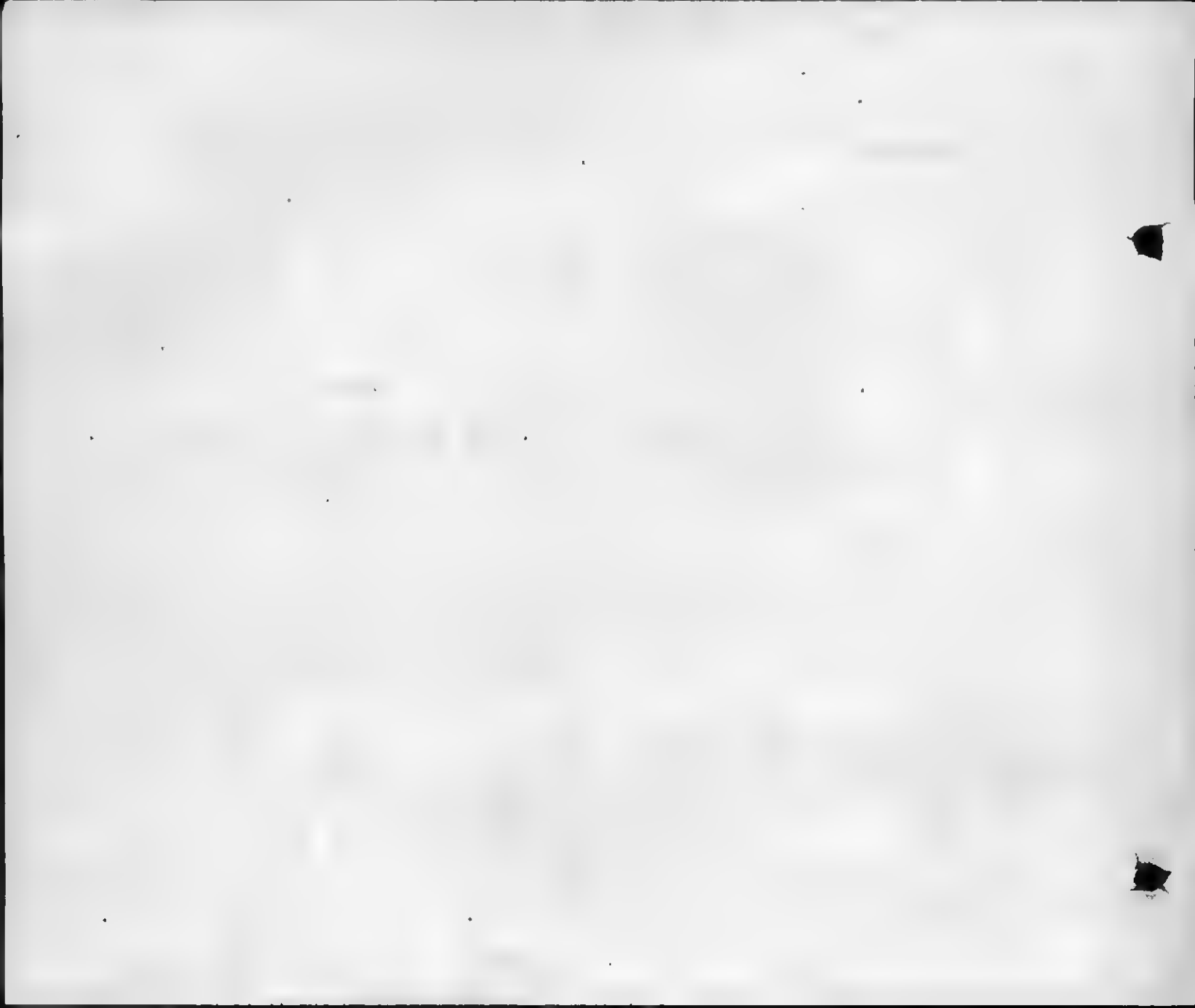
VR A15 (4)
15M

7283

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07277

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 55 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last HAZEL MAY MILLER		4. DATE OF DEATH Month Day Year JUNE 4 19 61	
5 SEX FEMALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/9/1885
9. AGE (In years last birthday) 75 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11 BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL I. ROHRER		14. MOTHER'S MAIDEN NAME MARY C. NELSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. TOM O. MILLER		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary thrombosis DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 7hr. 7hr. 10yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. : 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Feb. 1949 to June 4 1961 . that (I) (we) last saw the deceased alive on June 4 1961 , and that death occurred at 8 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffner		22b. DATE SIGNED 6/6/61	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffner		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/7/61	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24 FUNERAL DIRECTOR'S SIGNATURE W. J. Norman, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 '61	
25b. REGISTRAR'S SIGNATURE Charles S. Kraus			

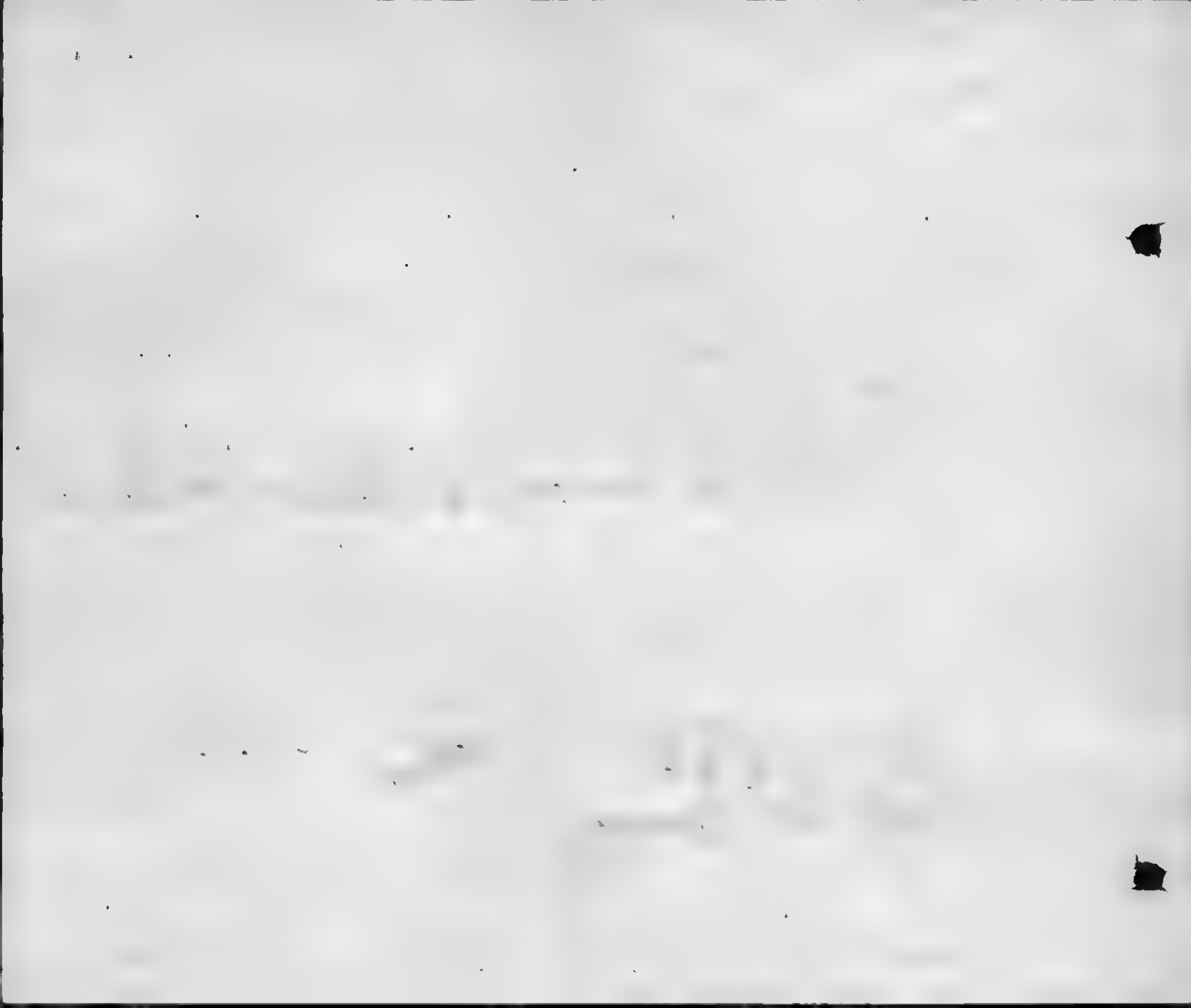


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be extended within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7289 07273
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>40 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>141 N. Conococheague St.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>141 N. Conococheague St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Daniel Frederick Mitchell Sr.</u> First Middle Last		4. DATE OF DEATH <u>June 16 19 61</u> Month Day Year	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>July 7 1888</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 72 yrs. 11 8 Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tannery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>(unknown) Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 09 7356</u>	
17. INFORMANT <u>Daniel F. Mitchell Jr.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Ed myocardial infarction and atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <u>Ed myocardial infarction and atherosclerosis</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) <u>Williamsport</u> County <u>Md.</u> (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/6/61</u> to <u>6/16/61</u> that (I) (we) last saw the deceased alive on <u>6/6/61</u> and that death occurred on <u>6/16/61</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Albert S. Young</u>		22b. DATE SIGNED <u>6/16/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Albert S. Young</u>		22d. ADDRESS <u>Williamsport, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 19-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town or county) <u>Williamsport Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert S. Young</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. DATE <u>JUN 19 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7290

07273

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Washington	
		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. LENGTH OF STAY IN It 42 years e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 722 Potomac Ave.	
3. NAME OF DECEASED (Type or print) Clyde Francis Moats First Middle Last		4. DATE OF DEATH Month June Day 4 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min 70	11. IF UNDER 24 HRS Months 70 Days 70 Hours 70 Min 70
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY wall paper	
11. BIRTHPLACE (State or foreign country) Tilghmanton, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Moats		14. MOTHER'S MAIDEN NAME Anne Munson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Arthur M. Moats		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 171X DUE TO uremia due to hydrophoria Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of Prostrate (c) Hypertensive Cancer-vascular Disease		INTERVAL BETWEEN ONSET AND DEATH May 5 - 1961	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arterio-sclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from May 5, 1961 to June 4, 1961 , that (I) (we) last saw the deceased alive on June 4, 1961 , and that death occurred at 3:55a from the causes and on the date stated above.	
22a. SIGNATURE Sidney Novenstein M.D.		22b. DATE SIGNED 6-5-61	
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		22d. ADDRESS FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-6-61	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	23d. LOCATION (City, town, or county) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR Hagerstown, Md.	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline		DATE JUN 8 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



7291

CERTIFICATE OF DEATH

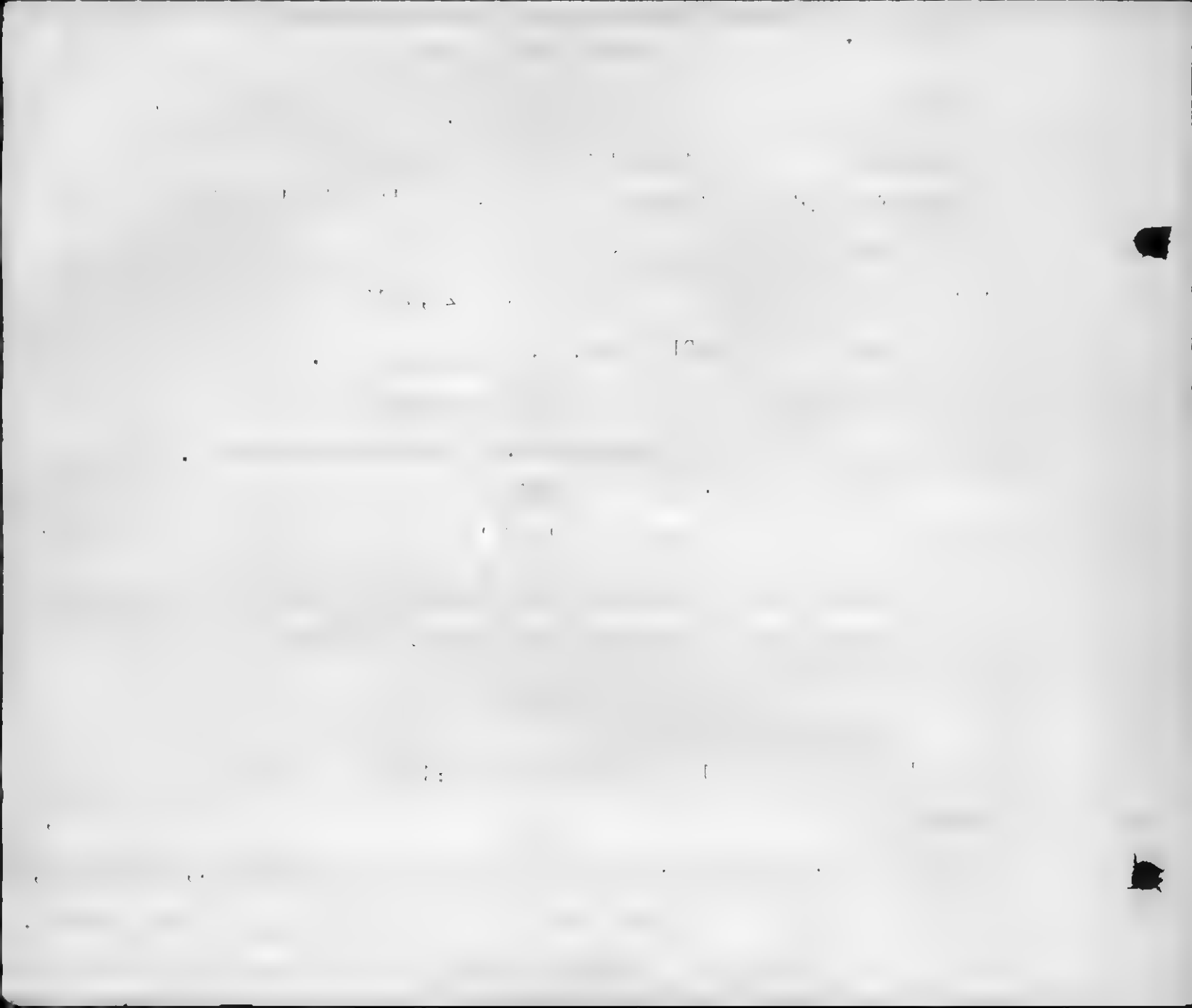
Reg. Dist. No.

07260

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PA. b. COUNTY FRANKLIN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WAYNESBORO			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 247 PHILADELPHIA AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) GARDNER HOWELL MOATS				4. DATE OF DEATH Month JUNE Day 7 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 20, 1915	
9. AGE (In years last birthday) 46 yrs		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS. Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Maintenance				10b. KIND OF BUSINESS OR INDUSTRY LANDIS MACH. CO.		11. BIRTHPLACE (State or foreign country) Tilghmanton, Md.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME J. Leslie Moats				14. MOTHER'S MAIDEN NAME Mary Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-3118		17. INFORMANT Mrs. Mabel Moats, Waynesboro Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 483X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBO PHLEBITIS LEFT LEG DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES ONE WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic carcinoma, disseminated, lungs, bilateral.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from JUNE 7 , 19 61 , to JUNE 7 , 19 61 , that I last saw the deceased alive on JUNE 7 , 19 61 , and that death occurred at 9:10PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 131 W. WASHINGTON ST., HAGERSTOWN, MD. DATE SIGNED JUNE 7, 61							
ACTUAL SIGNATURE John H. Kehne M.D.							
PHYSICIAN'S NAME (Type) JOHN H. KEHNE M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/61		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Z. Love, Waynesboro Pa.				24a. REC'D BY REGISTRAR JUN 9 61		24b. REGISTRAR'S SIGNATURE Arthur S. Finner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7292

CERTIFICATE OF DEATH

Reg. Dist. No. 67281

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>205 S. MONT VALLA AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KIMBERLY LYNN MURRAY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 11 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11 1961</u>	9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>25</u>		10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>WAYSON ANDREW MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>ELENOBA MAE GROVES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>June 11, 1961</u> , to <u>June 11, 1961</u> , that I last saw the deceased alive on <u>June 11, 1961</u> , and that death occurred at <u>2:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F. D. Dove Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DR. F. D. DOVE, JR.</u> <u>HAGERSTOWN, MD.</u>							
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF <u>6/12/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W.C.H.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Turner, M.D.</u>				ADDRESS <u>Wash County Hosp.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 15 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clinton L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4

may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

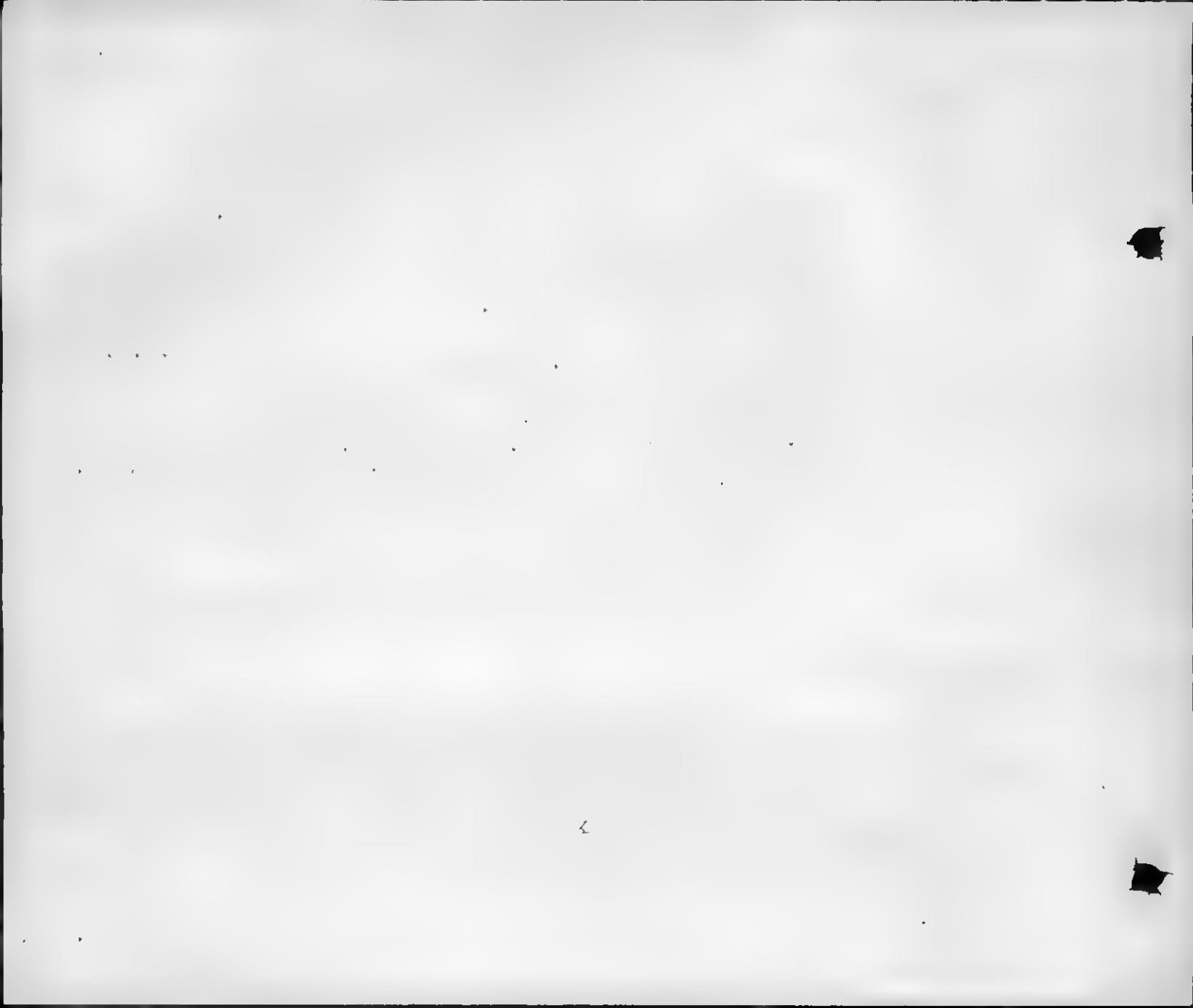
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7293

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07282

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>3 mos</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>John William MYERS</u>				4. DATE OF DEATH Month <u>6</u> Day <u>5</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 22, 1899</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>5</u> Hours <u>15</u> Min <u>15</u>	IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Continental Baking Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Shepherdstown</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>William Myers</u>				14. MOTHER'S MAIDEN NAME <u>Anna Coe Brotherton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, (If yes, give war or dates of service)) <u>no</u>				16. SOCIAL SECURITY NO. <u>578-09-6641</u>			
17. INFORMANT <u>Mrs. Margaret A. Myers</u>				Address <u>8648 Piney Branch Rd., Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>LOBULAR pneumonia, bilateral</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of larynx & carcinomatosis</u> (c) <u>4 1/2 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>March 24, 1961</u> to <u>June 5, 1961</u> , that (I) <u>met</u> last saw the deceased alive on <u>June 5, 1961</u> , and that death occurred at <u>4:30</u> from the causes and on the date stated above							
22a. SIGNATURE <u>Victor L. Ramos</u> M.D.				22b. DATE SIGNED <u>JUNE 5, 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>VICTOR L. RAMOS, M.D.</u>				22d. ADDRESS <u>Western Md. State Hospital Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/7/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Shepherdstown, Jefferson City, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Kline</u> DATE <u>JUN 8 '61</u>			
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7294

7283

7294

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>CANADA</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Rural Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN RD # 5</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID NIGH SWANDER</u>				4. DATE OF DEATH Month Day Year <u>June 14 1961</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 23 1886</u>	
9. AGE (in years last birthday) <u>74</u> yrs		IF UNDER 1 YEAR: Months Days Hours		IF UNDER 24 HRS: Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>		11. BIRTHPLACE (State or foreign country) <u>Canada</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>							
13. FATHER'S NAME <u>Enos Nighswander</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Burkholder</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Stouffville Canada</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 4-20-61 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>Indefinite</u> <u>Indefinite</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 14 1961</u> to <u>June 14 1961</u> , that (I) (we) last saw the deceased alive on <u>Dead on arrival</u> , and that death occurred on <u>June 14 1961</u> at <u>6:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u>				22b. DATE SIGNED <u>6/15/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>6/18/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stouffville Canada</u>		23d. LOCATION (City, town or county) (State) <u>Stouffville, Canada.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u> ADDRESS <u>Greencastle, Pa.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 16 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneis</u>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

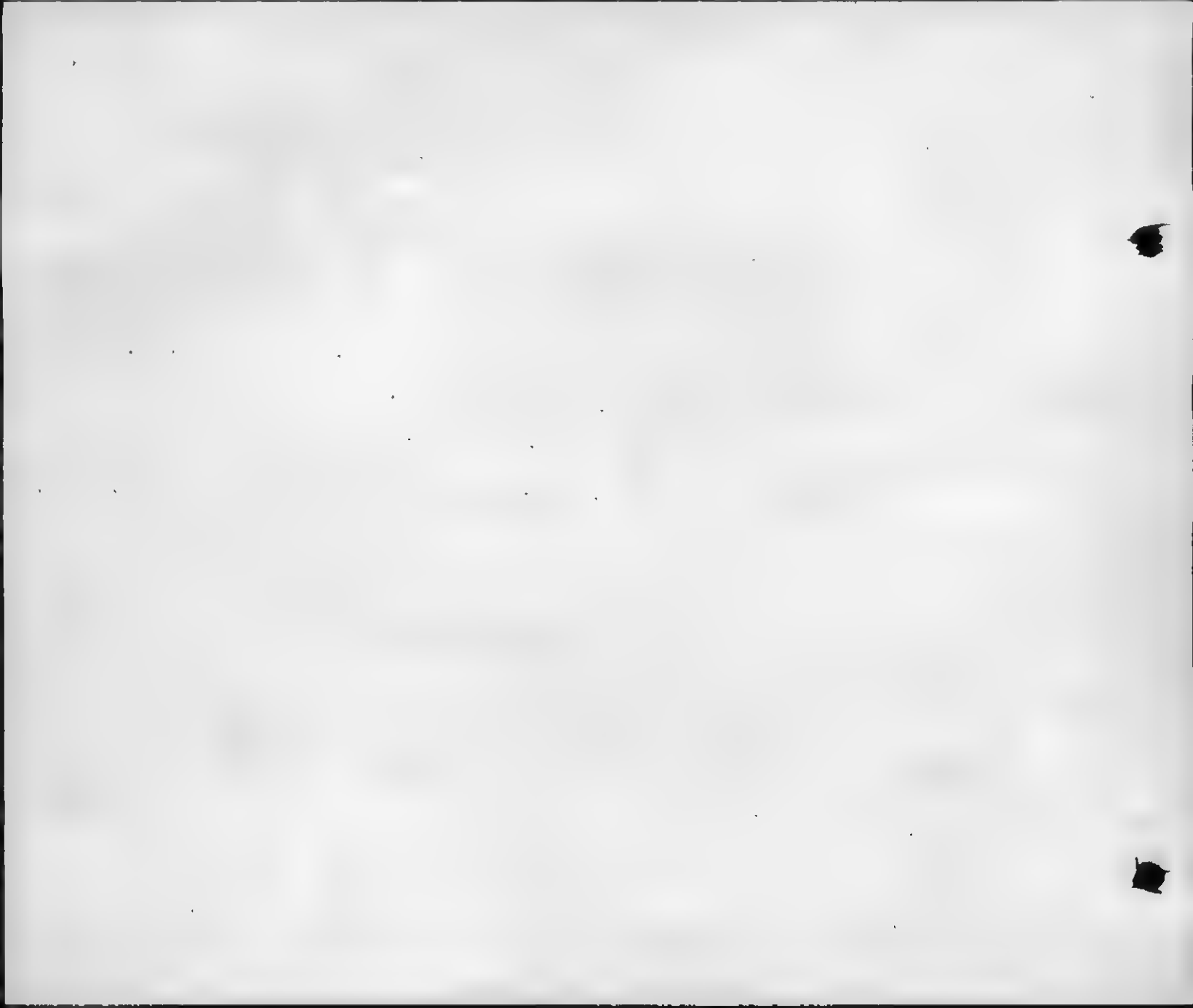
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07284

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write <u>Williamsport</u> and give nearest town) c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Downsville Pike</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write <u>Williamsport</u> and give nearest town) d. STREET ADDRESS <u>Downsville Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Russell</u> Last <u>Norris</u>				4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5 1906</u>	
9. AGE (In years last birthday) <u>54</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Weaverton Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>William A Norris</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle E. Rowe</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>705 12 5649</u>		17. INFORMANT <u>Mr. Fred Paxton</u> Address <u>404 York Place</u>			
				Cumberland Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ch. Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO <u> </u> (c) DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>6/19/61</u> to <u>6/19/61</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>6/19/61</u> and that death occurred on <u>6/19/61</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert L. Young</u>				22b. DATE <u>6/19/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Robert L. Young</u>	
22d. ADDRESS <u> </u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Boonsboro Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u> ADDRESS <u>Williamsport, Md</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 22 '61</u>		25b. REGISTRAR'S SIGNATURE <u> </u>	



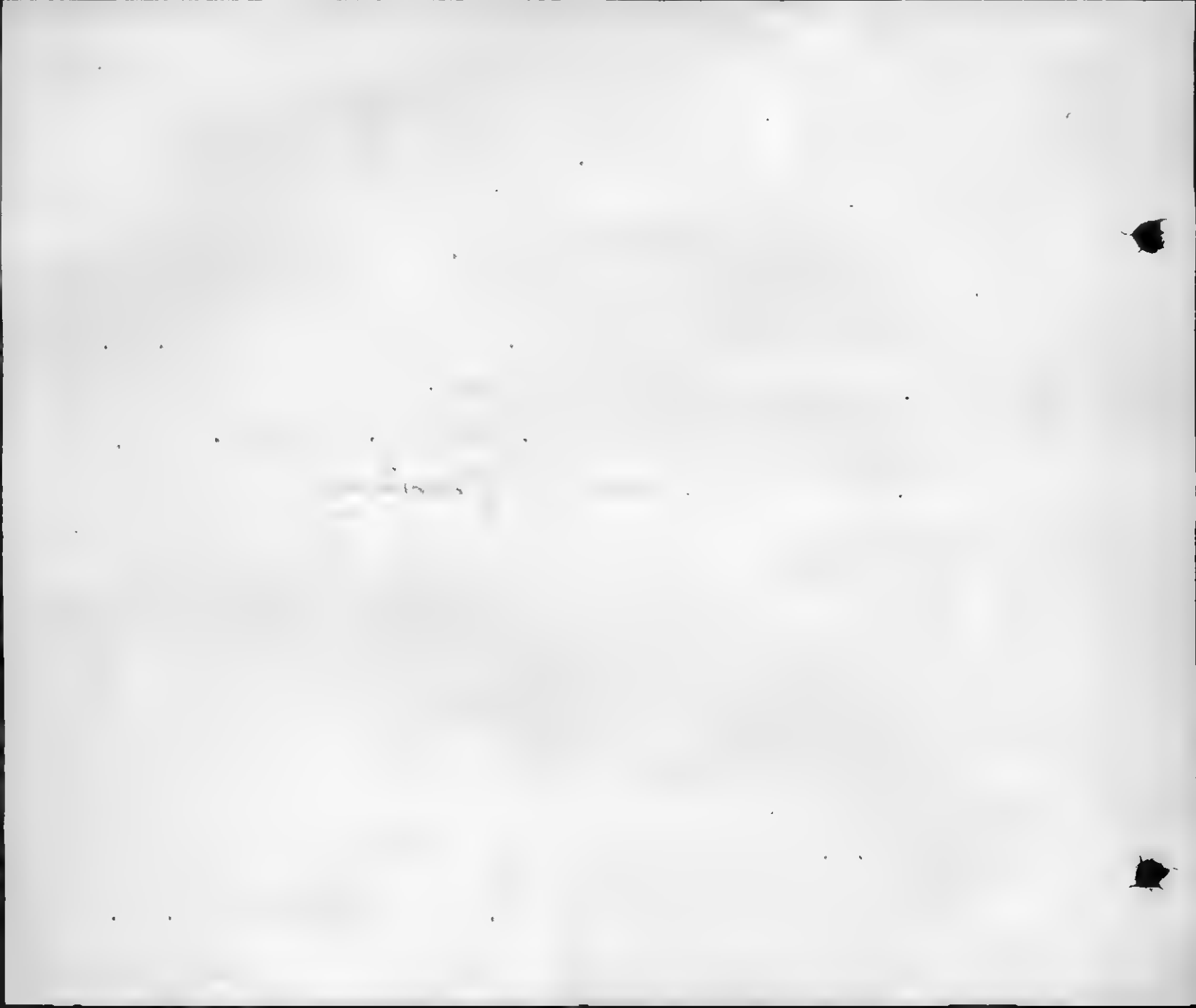
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (M)
15M 9/59

1
7296
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07285

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 1/2 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1620 DUAL HIGHWAY		e. STREET ADDRESS 1620 DUAL HIGHWAY	
3. NAME OF DECEASED (Type or print) First STEWART Middle CLARK Last PAXTON SR.		4. DATE OF DEATH Month JUNE Day 18 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1865
9. AGE (In years lost birthday) 95 yrs		10. IF UNDER 1 YEAR Months 95 Days 95 Hours 95 Min. 95	11. IF UNDER 24 HRS Months 95 Days 95 Hours 95 Min. 95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PATTERN MAKER MACHINERY MFG.		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSIAH PAXTON		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. STEWART C. PAXTON JR.		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Myocardial Regeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, general DUE TO (c) 1 yr. years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1 yr. years INTERVAL BETWEEN ONSET AND DEATH 1 yr. years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 6-18 o. m. 61 p. m. 6-18 19 61		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-18 19 61 to 6-18 19 61 , that (I) (we) last saw the deceased alive on 6-18 19 61 and that death occurred at 9P M. from the causes and on the date stated above.			
22a. SIGNATURE D. J. Boyer, M.D.		22b. DATE SIGNED 6-19-61	
22c. PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		22d. ADDRESS 135 N. Potomac Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/20/61	
23c. NAME OF CEMETERY OR CREMATORY ELK VIEW CEM.		23d. LOCATION (City, town, or county) (State) CLARKSBURG W. VA.	
24. FUNERAL DIRECTOR'S SIGNATURE W. H. Norman		25a. REC'D BY REGISTRAR JUN 21 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume			



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7297

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07286

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 5 mo. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION W. Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Woodbine d. STREET ADDRESS R.D. # 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harvey Middle Russell Last PICKETT		4. DATE OF DEATH Month 6 Day 2 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-15-1902
9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months 58 Days 5 Hours 10 Min. 10	11. IF UNDER 24 HRS Months 58 Days 5 Hours 10 Min. 10
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer-retired		10b. KIND OF BUSINESS OR INDUSTRY owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME Harvey E. Peikett		14. MOTHER'S MAIDEN NAME Florence I. Conaway	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO 216-22-7596	
17. INFORMANT Mrs. Bertha K. Pickett-- same as 2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO (b) Paronchymatous Cerebellar degeneration DUE TO (c) 10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) glioma, right frontal lobe, subtotally removed in 1950		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 12, 1961 to June 2, 1961 , that (I) was saw the deceased alive on June 2, 1961 , and that death occurred at 5:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun		22b. DATE SIGNED June 3, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6-5-1961	
23c. NAME OF CEMETERY OR CREMATORY Winfield Church of God		23d. LOCATION (City, town, or county) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz,		25a. REC'D BY REGISTRAR DATE JUN 6 '61	
ADDRESS Winfield, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

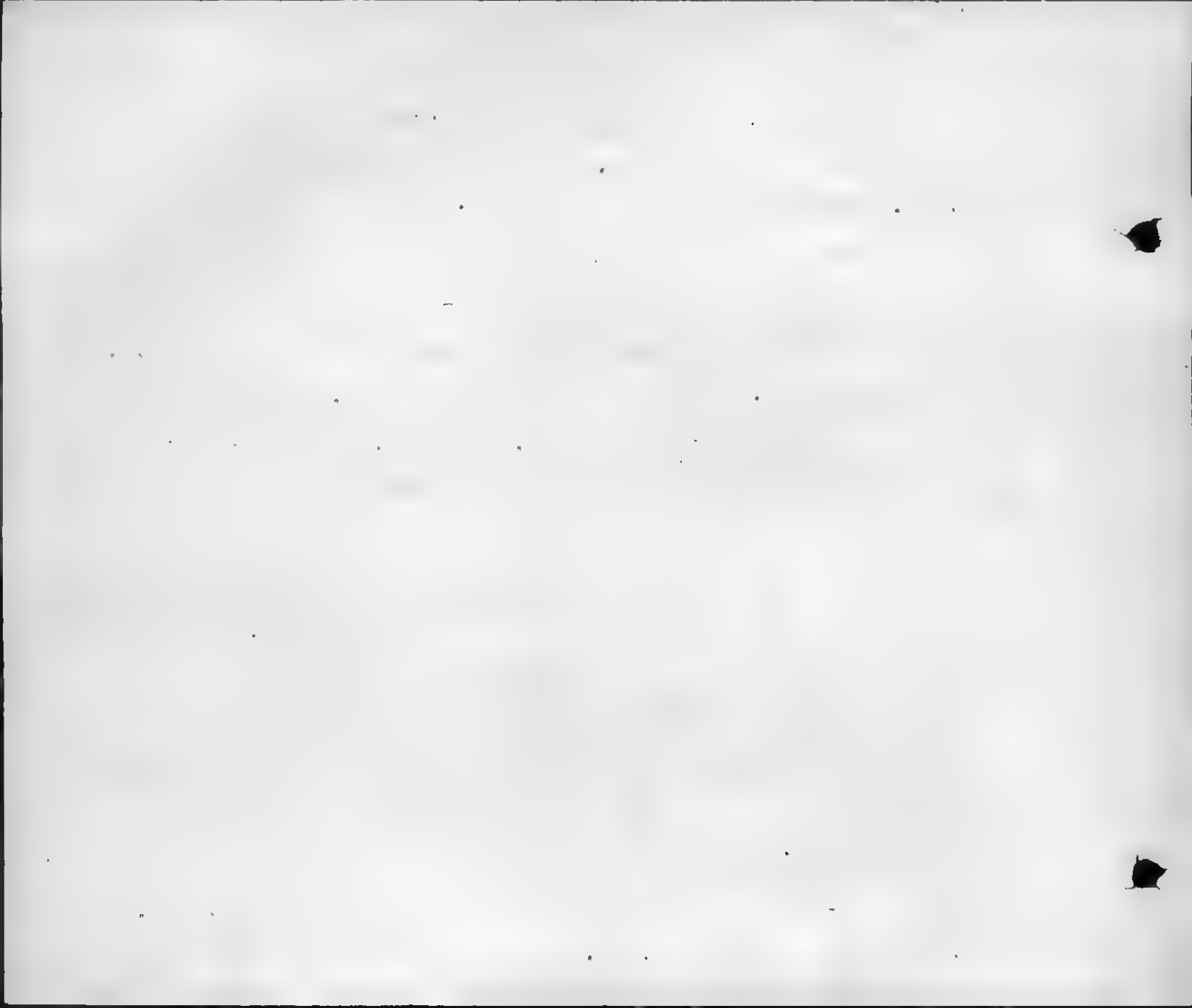
(M)

(I)

2

1

2



Colony 8 ft.

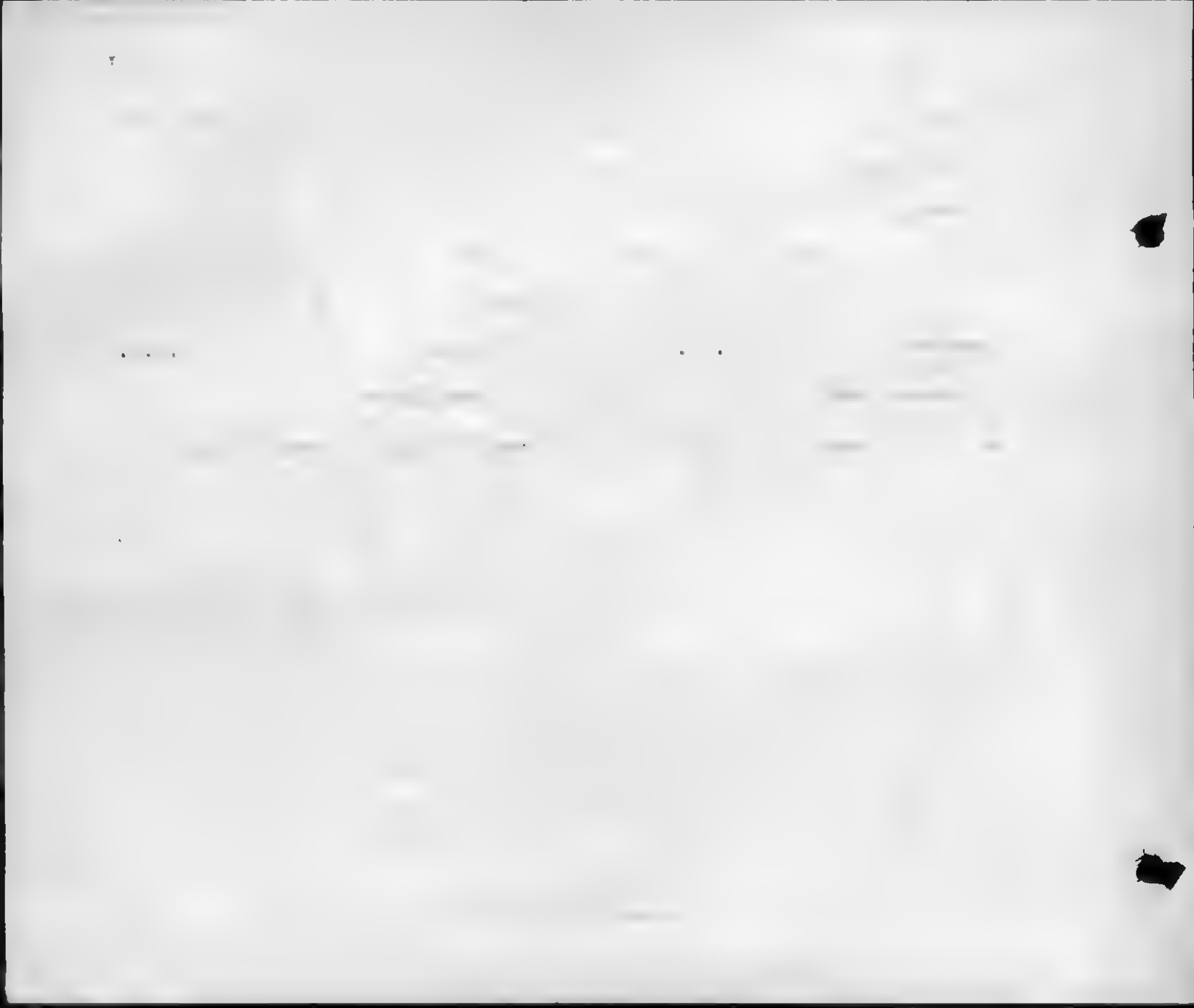


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7299

07288

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 Weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pectonville</u> d. STREET ADDRESS <u>Pectonville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Walter</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1961</u>					
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/1899</u>		9. AGE (In years last birthday) <u>61</u> yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md. R R</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jeremiah Reed</u>			14. MOTHER'S MAIDEN NAME <u>Emma Bloyer</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-10-7933</u>		17. INFORMANT <u>Elsie May Reed</u> Address <u>Hancock Route #3</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>GENERALIZED Abdominal CARCINOMATOSIS</u> <u>153.3</u> DUE TO <u>CARCINOMA OF Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 yr.</u> (c) <u>1 yr.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)							
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Dec. 1, 1960</u> to <u>June 2, 1961</u> that (I) <u>(last)</u> saw the deceased alive on <u>Jun 2, 1961</u> , and that death occurred at <u>4P</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>John A. Moran</u>		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN.</u>			
22d. ADDRESS <u>215 W. WASHINGTON ST., HAGERSTOWN.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Orchard Ridge Church</u>			
23d. LOCATION (City, town, or county) (State) <u>Washington Maryland</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hare</u>		25a. REC'D BY REGISTRAR <u>June 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



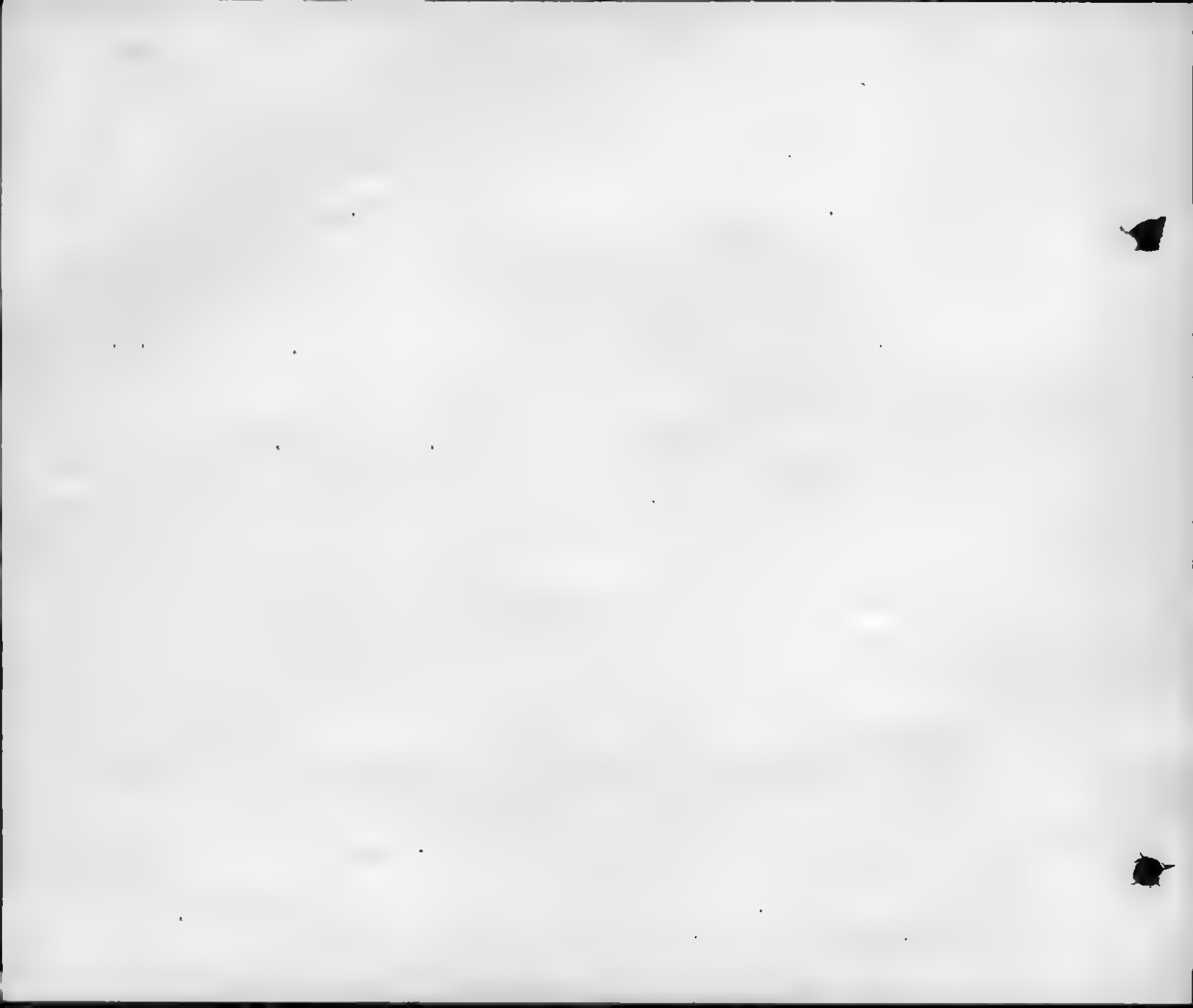
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7300

07289

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Mapleville c. LENGTH OF STAY IN 1b 6 month d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boonsboro Md. RFD 2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Mapleville d. STREET ADDRESS Boonsboro Md. RFD #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Vass Last Renner		4. DATE OF DEATH Month June Day 18 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882 March 3 1882
9. AGE (in years last birthday) 79 yrs		10. IF UNDER 1 YEAR Months 3 Days 14 Hours Min. 	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Williamsport Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Alex Mc Kelvey	
14. MOTHER'S MAIDEN NAME Mary Singer		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mapleville Boonsboro Raymond R. Renner Md. RFD #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Hypertension in later stages Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart disease DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 74
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day Year Hour a. m. 19 p. m. 	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1960 to June 14, 1961 , that (I) (we) last saw the deceased alive on June 14, 1961 , and that death occurred at 8 PM , from the causes and on the date stated above.	
22a. SIGNATURE G. W. L. L. L.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. W. L. L. L.		22d. ADDRESS Boonsboro Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21-61	
23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf		25a. REC'D BY REGISTRAR William S. Hume DATE JUN 22 '61	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A15 (4)
15M 9/59

1
7301
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07290

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural State Line Pa</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Hospital</u>		d. STREET ADDRESS <u>7</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>T</u> Last <u>RIPPLE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1881</u>
9. AGE (In years lost birthday) <u>79</u> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Ripple</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>None</u>	
17. INFORMANT <u>Mrs. Minnie Ripple</u>		Address <u>State Line Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of Gall Bladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>None</u> DUE TO (c) <u>None</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>60</u> , to <u>June 24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 23</u> 19 <u>61</u> , and that death occurred at <u>7 P.</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. John D. Turco</u>		22b. DATE SIGNED <u>6-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>for Dr. Eldon Hoachlander</u>		22d. ADDRESS <u>302 N. Potomac Street-Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>near Hagerstown Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Muenich</u>		25. REC'D BY REGISTRAR <u>June 29 '61</u>	
ADDRESS <u>Greencastle Pa</u>		25b. REGISTRAR'S SIGNATURE <u>Clinton S. Knaus</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

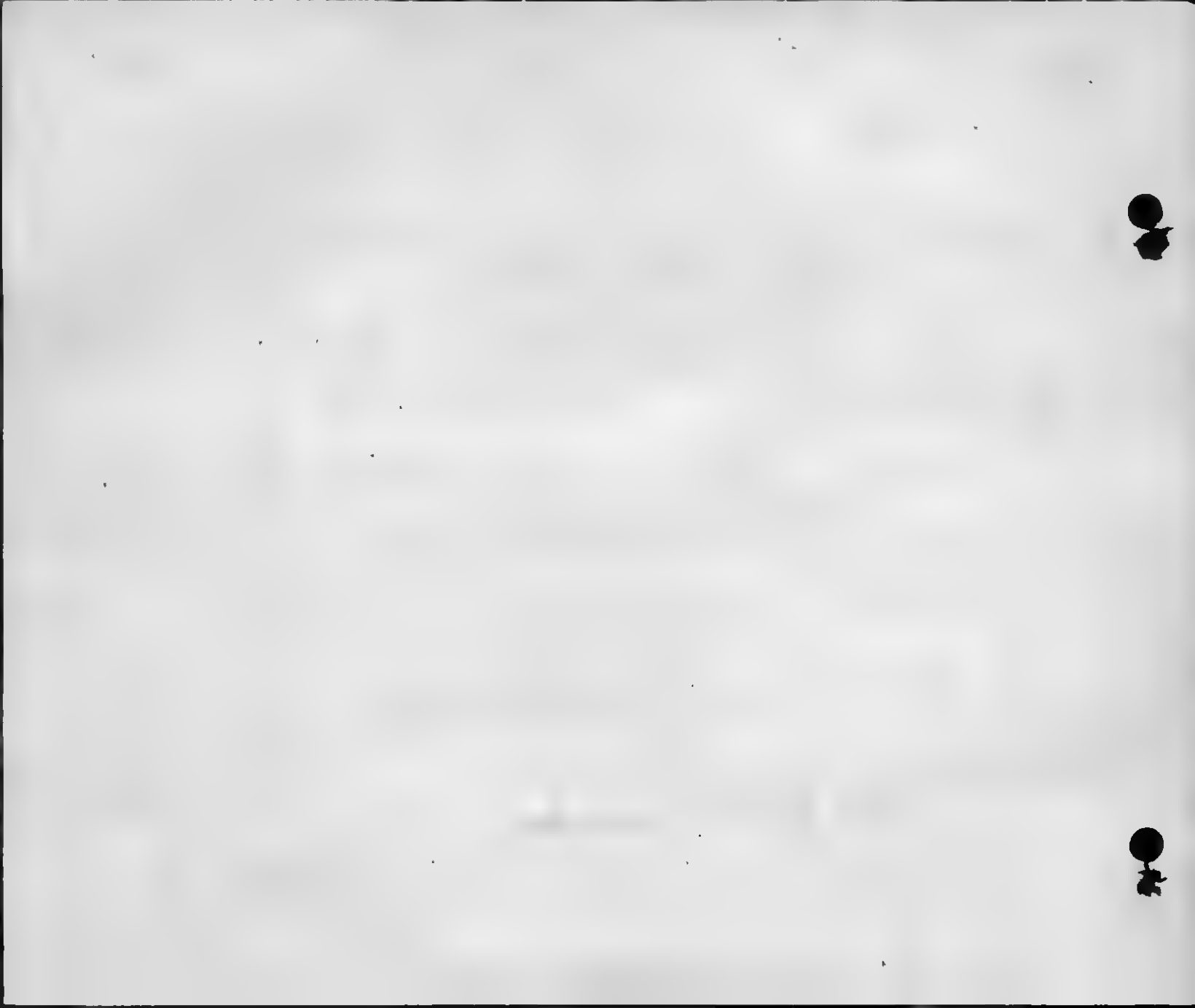
CERTIFICATE OF DEATH

7302

07291

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN <u>2 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt Royal Apts</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>Mt Royal Apts</u>											
3. NAME OF DECEASED (Type or print) <u>MILDRED TEAGUE SCHOEN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>1961</u>											
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jany 16 1903</u>									
9. AGE (In years last birthday) <u>58</u> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> </tr> <tr> <td></td> <td>Hours</td> </tr> <tr> <td></td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days		Hours		Min.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (County & State or foreign country) <u>Balt. Co. Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
	Hours														
	Min.														
13. FATHER'S NAME <u>Merrill Teague</u>				14. MOTHER'S MAIDEN NAME <u>Ada C. Hair</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Unable to locate</u>											
17. INFORMANT <u>Unable to locate</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> (b) <u>Arteriosclerotic heart disease</u> (c) <u>Indefinite</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>1950, death</u> 19....., that (I) (we) last saw the deceased alive on <u>June 8, 1961</u> and that death occurred at <u>M</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>Paul Harrison</u>				22b. DATE SIGNED <u>6-10-61</u>											
22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison, M. D.</u>				22d. ADDRESS <u>318 N. Potomac St., Hagerstown, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/10/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. It may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

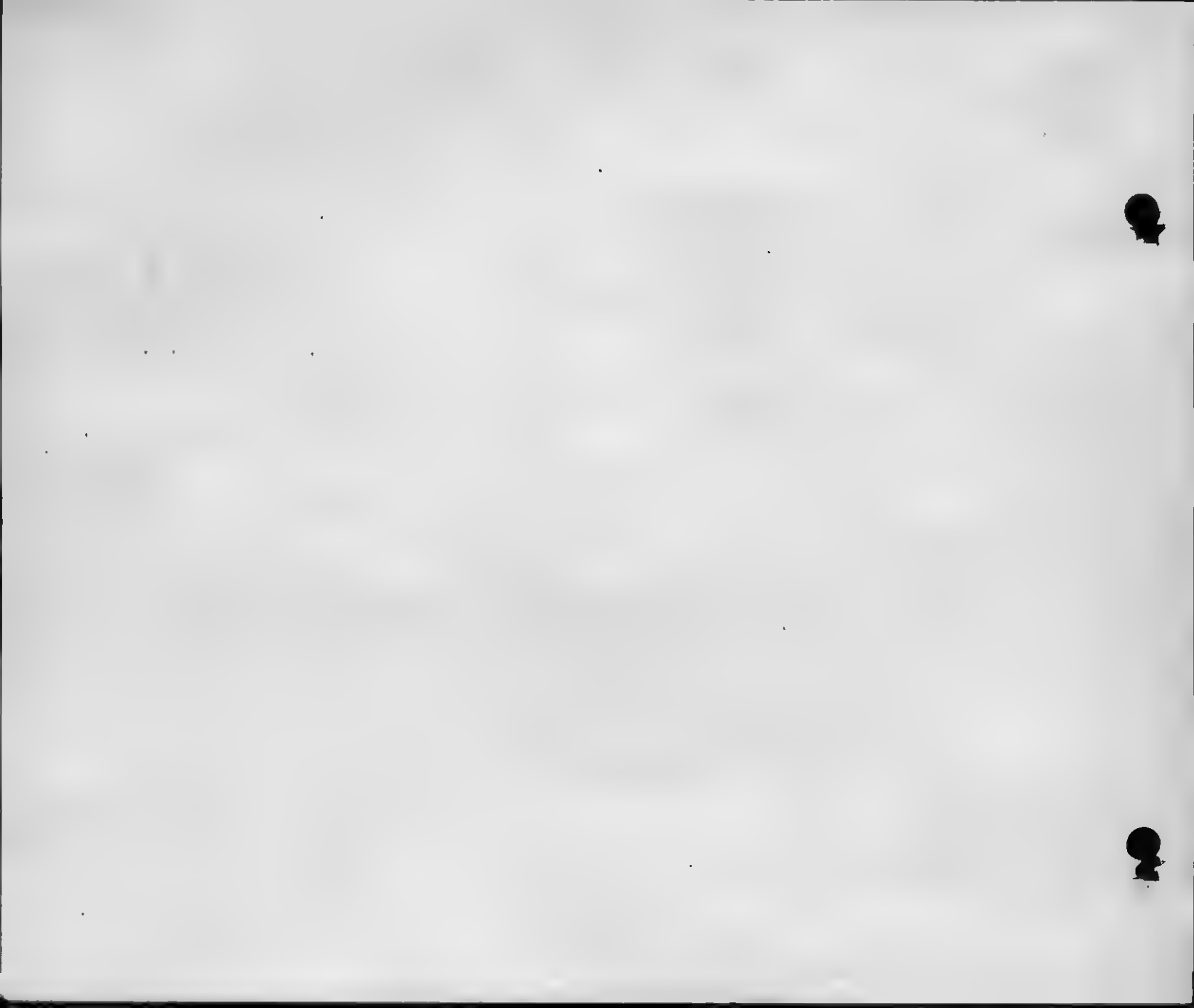
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

C7292

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If air is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>3 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>18 Sunset Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Patricia</u> Middle <u>Shank</u> Last <u>Shank</u>		4. DATE OF DEATH Month <u>June</u> Day <u>8</u> Year <u>19 61</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 8 1961</u>			
9. AGE (In years last birthday) <u>3</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>			
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Thomas Henry Shank</u>			
14. MOTHER'S MAIDEN NAME <u>Tomasita Montes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Thomas Henry Shank</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete Myocardial Infarction</u> 560.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last, DUE TO _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): <u>Blow from 9:30 AM steel in operating table 2:15 PM</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Blow from 9:30 AM steel in operating table 2:15 PM</u>		20c. TIME OF INJURY Month, Day, Year <u>19 61</u> Hour a.m. _____ p.m. _____			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Williamsport</u>		20f. (City or town) <u>Williamsport</u>			
20g. (County) <u>Washington</u>		20h. (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John E. Williams</u>		EXAMINER'S NAME (Type) <u>John E. Williams</u>		DATE SIGNED <u>6/9/61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>			
22d. LOCATION (City, town, or country) <u>Williamsport</u>		22e. (State) <u>Md.</u>		23. FUNERAL DIRECTOR <u>Albert L. Leaf</u>			
23a. REC'D BY REGISTRAR <u>DAN L. 12 '61</u>		23b. REGISTRAR'S SIGNATURE <u>William S. Frank</u>		24. ADDRESS <u>Williamsport, Md.</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7304

07293

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 13 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 154 WEST NORTH STREET		e. STREET ADDRESS 154 WEST NORTH ST.	
3. NAME OF DECEASED (Type or print) HELEN D. SHOVE		4. DATE OF DEATH JUNE 29 - 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 15 - 1884
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 2 Days 14 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) NEAR DOWNSVILLE WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY CLAY BURGAN		14. MOTHER'S MAIDEN NAME MARY VIRGINIA BOWERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MISS VERA SHOVE		Address 154 WEST NORTH ST. HAGERSTOWN MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arterio Sclerotic Heart Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 yrs 10 yrs			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from June 29, 1961 to June 29, 1961 , that (I) (we) last saw the deceased alive on June 27, 1961 , and that death occurred 10:50 AM from the causes and on the date stated above.			
22a. SIGNATURE F F Lusby		22b. DATE SIGNED 30th 6/1	
22c. PHYSICIAN'S NAME (Type) F F Lusby		22d. ADDRESS 2301 N Potomac Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF July 2, 1961	
23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City, town or county) (State) HAGERSTOWN WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John A. East		25a. REC'D BY REGISTRAR DATE JUL 5 '61	
25b. REGISTRAR'S SIGNATURE Boonsboro MD.		25c. REGISTRAR'S SIGNATURE Linus S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Pages 3 and 4 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. FUSBY
2301 N. POTOMAC
HAGERSTOWN

VR A15 (4)
15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

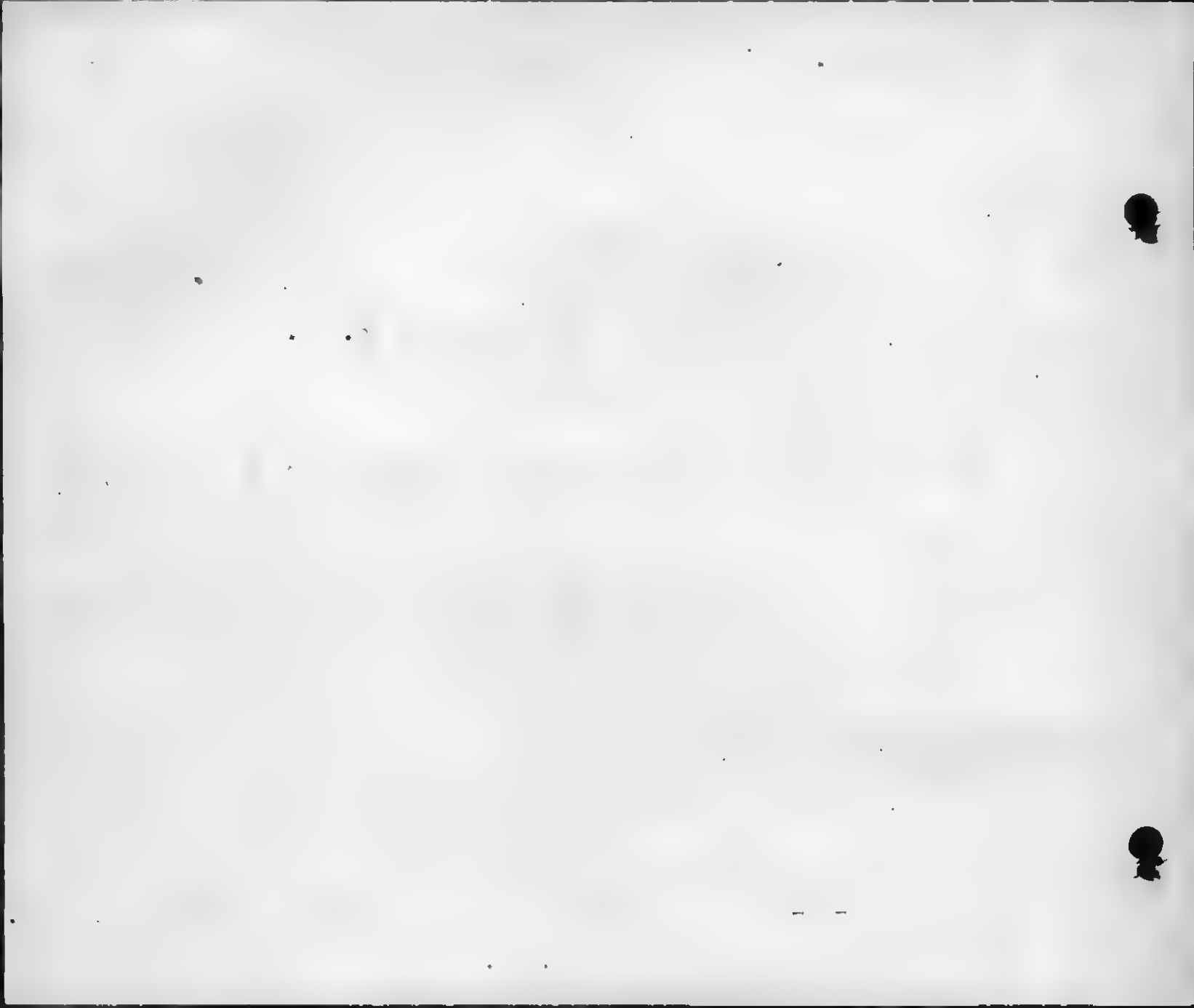
7305

07294

1. PLACE OF DEATH a. COUNTY <u>Washington Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 yrs +</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hedgesville, Route 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>Route 2</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Pet</u> Last <u>Shriver</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Garhart</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>Mary Hedrick, Falling Waters W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> DUE TO <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Cachexia ② Pyoderma</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month _____ Day _____ Year <u>19</u> Hour _____ a. m. _____ p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (1) (this hospital) attended the deceased from <u>Aug 1950</u> to <u>June 16, 1961</u> , that (1) (we) last saw the deceased alive on <u>6-16</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Byrkit</u>				22b. DATE SIGNED <u>6-16-61</u>		22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>	
22d. ADDRESS <u>Williamsport, W. Va.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-19-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hedgesville, Rt. # 2, W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u>				ADDRESS <u>Martinsburg, W. Va.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

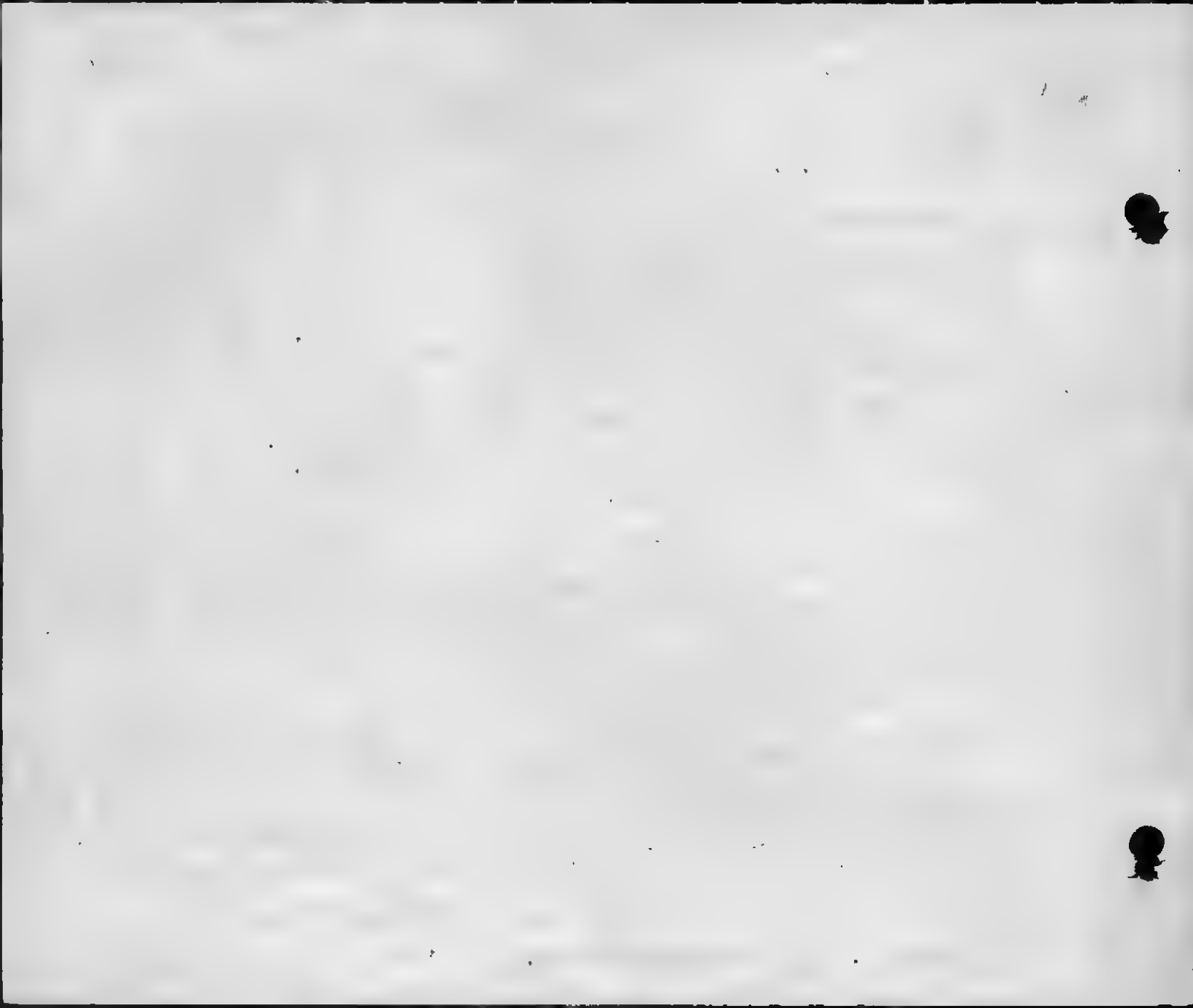
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7306

07295

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Hagerstown R.F.D</u> c. LENGTH OF STAY IN b. <u>5 Wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Avalon Manor</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>Hagerstown</u> d. STREET ADDRESS <u>209 West Irvin Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF (Type or print) <u>HOWARD</u> <u>ERNEST</u> <u>SLAGEN</u>		4. DATE OF DEATH Month <u>June</u> Day <u>21</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 25 1870</u>	9. AGE (In years) (If UNDER 1 YEAR, last birthday) Months <u>91</u> Days <u>91</u> Hours <u>91</u> Min <u>91</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>College Professor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	11. BIRTHPLACE (County & State of birth; foreign country) <u>MD. New Windsor Carroll Co</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Albert Slagen</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Bange</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs Label Kaylor</u> Address <u>209 W. Irvin Ave Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>153.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Inanition</u> (c) <u>Carcinoma of colon</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 days</u> <u>2 mo.</u> <u>4 mo +</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>1961</u> <u>to June 21, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 21, 1961</u> , and that death occurred at <u>11:45 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Clara A. Hoffman</u> M.D.		22b. DATE SIGNED <u>6/23/61</u>	
22c. PHYSICIAN'S NAME (Type or print) <u>Clara A. Hoffman</u>		22d. ADDRESS <u>214 N. Potomac St. Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt Carmel Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Littlestown Adams Co Pa</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>Hagerstown Md</u> 25b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u> DATE <u>JUN 26 '61</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

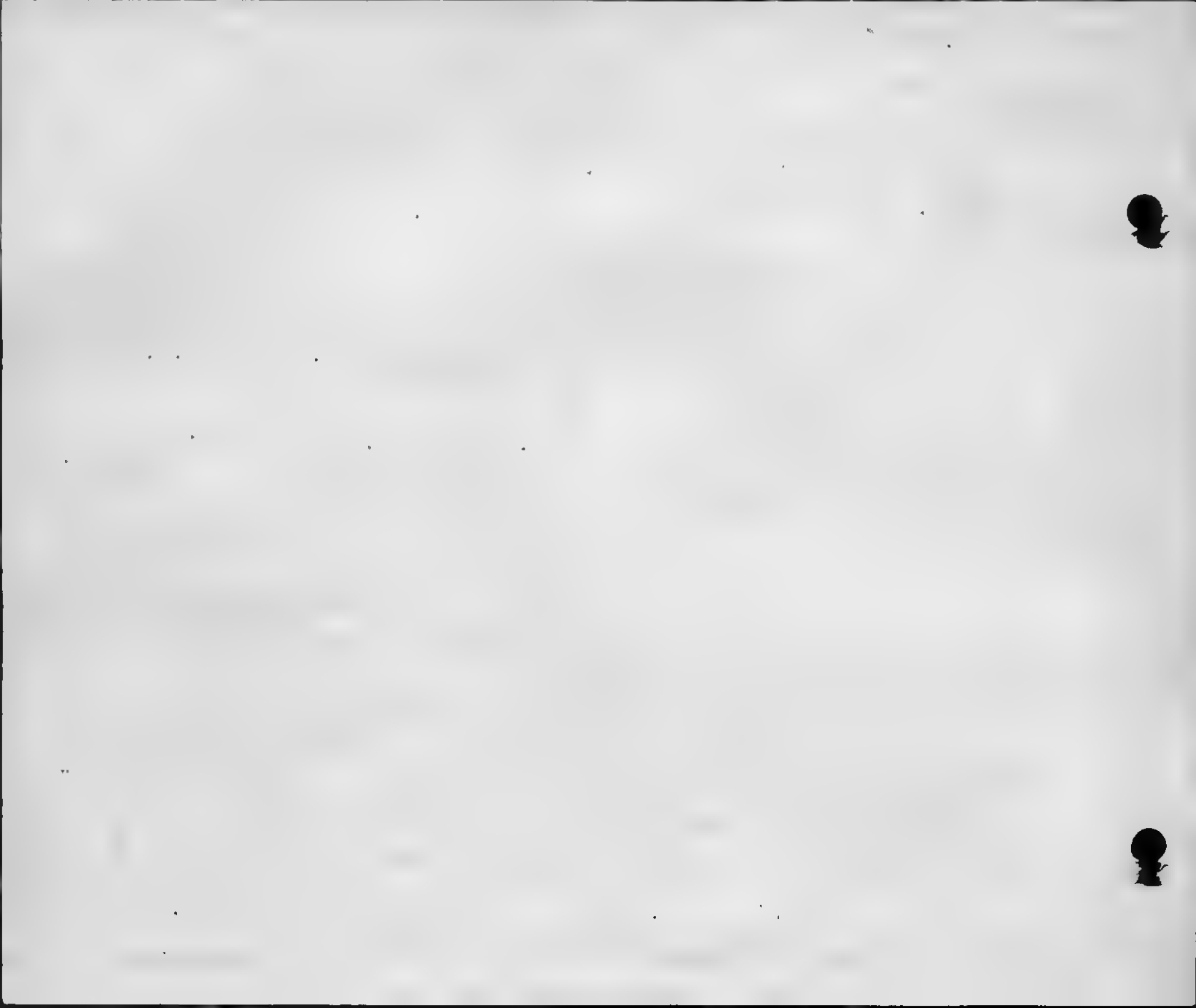
07296

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> c. LENGTH OF STAY IN 1b <u>55 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>200 E. Main Street</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>200 E. Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Aimee</u> Middle <u>Wilson</u> Last <u>Smith</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 23 1905</u>			
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Victor Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Grafton V. Smith</u> Address <u>200 E. Main St Sharpsburg Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> (c) <u>3 yrs.</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>			
20f. (City or town) <u> </u>		20g. (County) <u> </u>		20h. (State) <u> </u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 9, 1959</u> to <u>6/16, 1961</u> , that (I) (we) last saw the deceased alive on <u>6-10-1961</u> , and that death occurred at <u>9:25 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter H. Shealy</u> M.D.				22b. DATE SIGNED <u>6-18-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER H. SHEALY</u>				22d. ADDRESS <u>Sharpsburg Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>			
23d. LOCATION (City, town or county) <u>Sharpsburg Md.</u>		23e. (State) <u> </u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert E. Wolf</u> ADDRESS <u>Williamsport, Maryland</u>				25a. REC'D BY REGISTRAR <u> </u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>				DATE <u>JUN 20 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be obtained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



7308

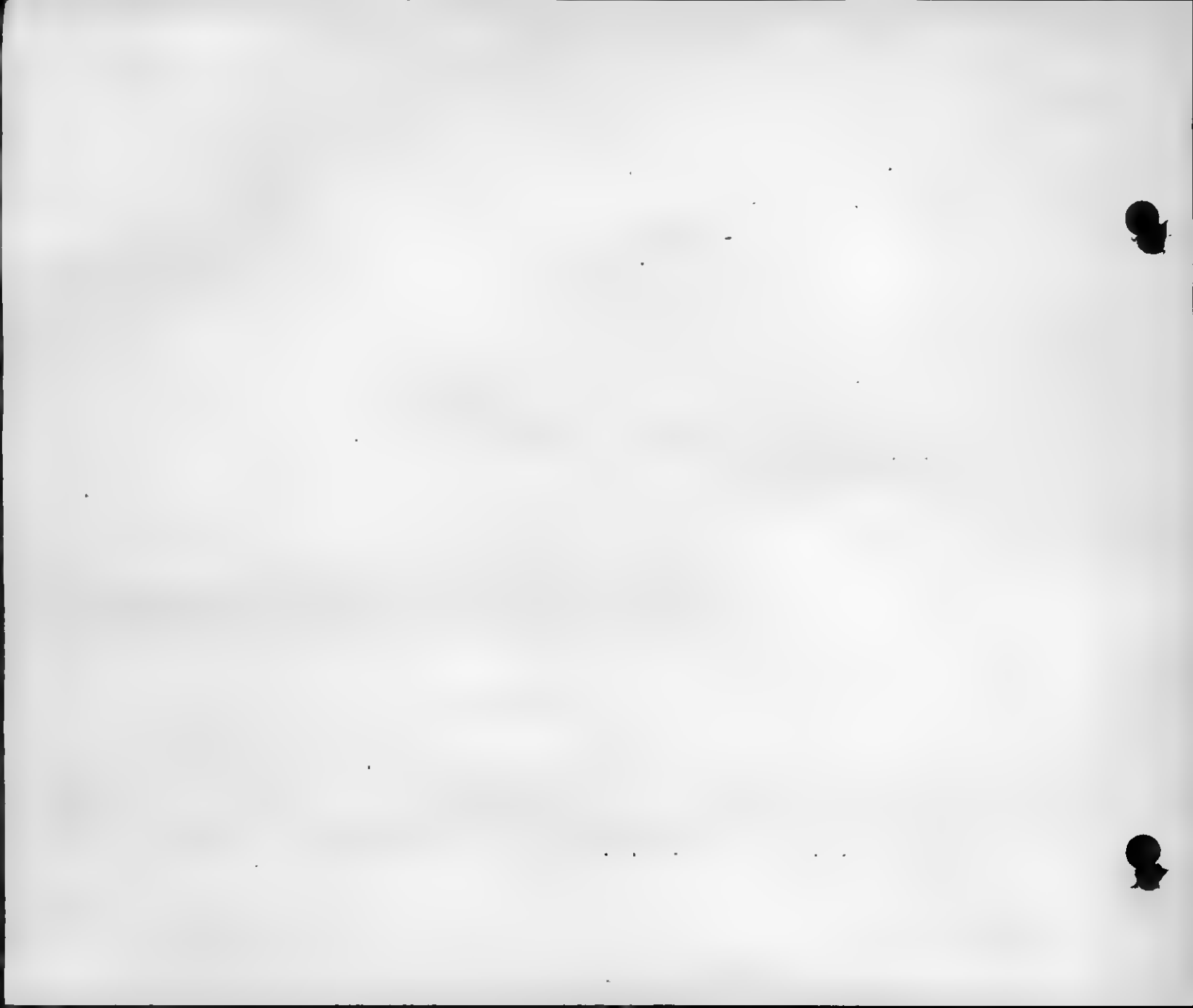
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07297

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
c. LENGTH OF STAY IN 1b <u>15 yrs</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1910 Virginia Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1910 Virginia Ave.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Geary</u> Middle <u>W.</u> Last <u>Snyder</u>				DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 2, 1868</u>	
9. AGE (In years lost birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTH PLACE (State or foreign country) <u>Washington Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John W. Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Zentger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mrs. Lohm. Schaper, Hagerstown, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>General arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Indefinite</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic hypertrophy benign</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5:40 P.M.</u> to <u>June 16, 1961</u> that (I) (we) last saw the deceased alive on <u>May 19, 1961</u> and that death occurred at <u> </u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>B.B. Kneisley</u> M.D.				22b. DATE <u>6/17/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>B.B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-19-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Washington Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Hagerstown, Pa.</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Carlton L. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be used by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7309

07298

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN TB <u>19 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>133 Summit Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>133 Summit Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First Middle Last <u>IRMA</u> <u>ELAINE</u> <u>SOUTH</u>				4. DATE OF DEATH Month Day Year <u>June</u> <u>14</u> <u>19 61</u>																			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 17, 1898</u>		9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Midland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>													
13. FATHER'S NAME <u>James Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Annie E. Askie</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.				17. INFORMANT Address <u>Mr. Frank P. South Hagerstown, Maryland</u>							
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Acute Myocardial Infarction</u> (c) <u>Advanced Arteriosclerotic heart disease + Coronary atherosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Apr 26, 1954</u> to <u>June 14, 1961</u> , that (I) (we) last saw the deceased alive on <u>May 34, 1961</u> , and that death occurred at <u>4:30 PM</u> , from the causes and on the date stated above.																							
22a. SIGNATURE <u>Edward W. Ditto III, M.D.</u>												22b. DATE SIGNED <u>6/14/61</u>											
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>												22d. ADDRESS <u>217 West Washington St.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/17/1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Cumberland, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Enter - Rouzer Funeral Home Hagerstown, Maryland</u>												25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <u>Charles E. Kline</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

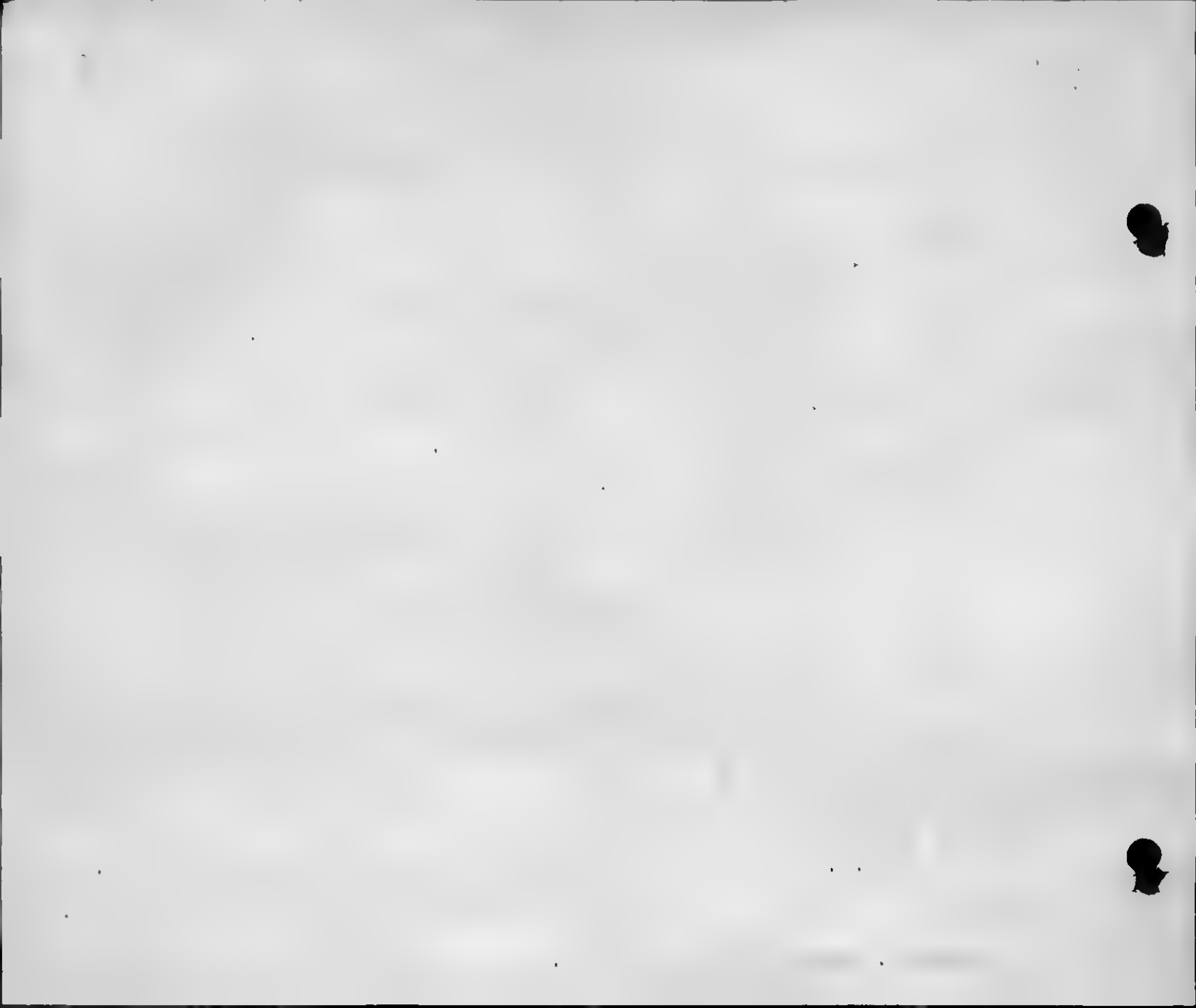


TO HEALTH OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7310													
CERTIFICATE OF DEATH													
07299													
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 c. LENGTH OF STAY IN 1b 68 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Funkstown				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X Hagerstown R # 3 d. STREET ADDRESS Funkstown									
3. NAME OF DECEASED (Type or print) Rev. SYRON FREDERICK SPITZER				4. DATE OF DEATH Month Day Year June 8 1961				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 13 1877		9. AGE (In years last birthday) IF UNDER 1 YEAR 83 yrs. Months Days		f. UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Wood Work				11. BIRTHPLACE (County & State, or foreign country) Broadway Rockingham Co Va.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Franklin P. Spitzer				14. MOTHER'S MAIDEN NAME Lydia Holsinger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. ---				17. INFORMANT Carroll F. Spitzer Hagerstown R # 3				Address Funkstown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypostatic Ephemeral Pneumonia DUE TO Acute Suppurative Parotiditis DUE TO Atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 4 days years				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 6-8-61 to 6-8-61 , that (I) (we) last saw the deceased alive on 6-8-61 , and that death occurred at 12 M, from the causes and on the date stated above.													
22a. SIGNATURE D. J. Boyer				M.D. Dr D. J. Boyer				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-9-61	
22c. PHYSICIAN'S NAME (Type) Dr D. J. Boyer				22d. ADDRESS No Potomac st Hagerstown Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/10/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				ADDRESS				25a. REC'D BY REGISTRAR JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7311

CERTIFICATE OF DEATH

07300

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in b. <u>30</u> Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>173 Summit Ave</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>173 Summit Ave</u>	
3. NAME OF DECEASED (Type or print) <u>ELSIE MAY STARLIPER</u>		4. DATE OF DEATH <u>June 30 1961</u> 19 <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>March 15 1886</u>	9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>03</u> Days <u>03</u> IF UNDER 24 HRS.: Hours <u>03</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Little Cove Penna</u>
13. FATHER'S NAME <u>William Starliper</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		14. MOTHER'S MAIDEN NAME <u>Malinda Cousins</u>	
16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Frank Carty Hagerstown</u> Address <u>I.d. R # 3</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic sclerotic Heart Disease with myocardial failure</u> DUE TO (b) <u>St. James Village</u> DUE TO (c) <u>myocardial failure</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (as hospital) attended the deceased from <u>Jan 1956</u> to <u>June 30 1961</u> , that (I) (as) last saw the deceased alive on <u>June 29 1961</u> , and that death occurred <u>ASCA</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>F F Lusby</u>		22b. DATE SIGNED <u>30 June 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>F F Lusby</u>		22d. ADDRESS <u>2301 Polman St</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>7/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash. Co. Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25. REC'D BY REGISTRAR <u>JUL 5 '61</u>	
25a. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		25b. REGISTRAR'S SIGNATURE	

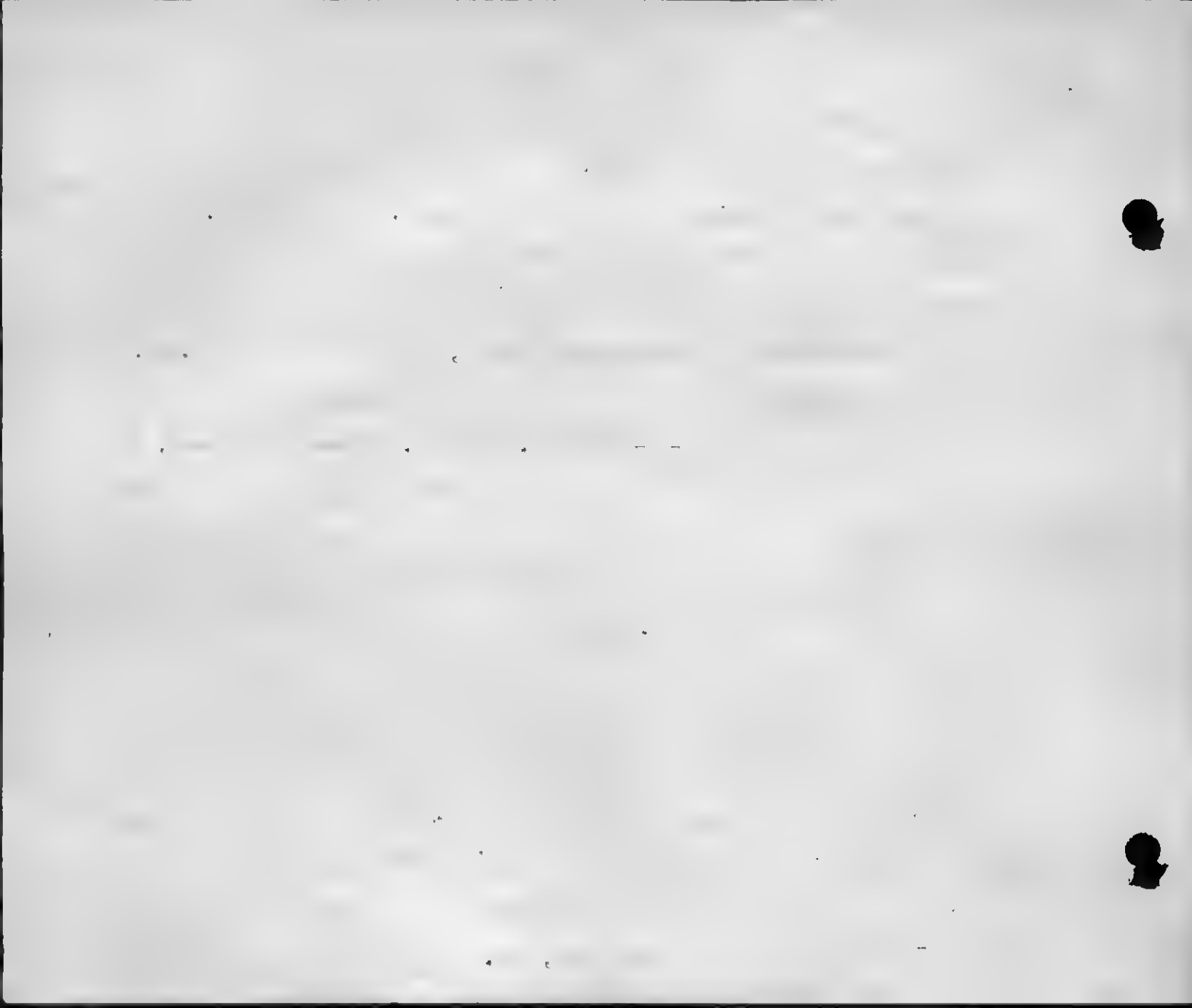


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7312 Item 25b, Film 0288 6/14/61 jwk											
CERTIFICATE OF DEATH											
07301											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN TB 30 years				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 235 N. Cleveland Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CESARIO STIVALETTI				4. DATE OF DEATH June 7 1961							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1896		9. AGE (in years last birthday) 65 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Quarry Worker				10b. KIND OF BUSINESS OR INDUSTRY Cement Company				11. BIRTHPLACE (County & State, or foreign country) Vasto, Italy			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Joseph Stivaletti				14. MOTHER'S MAIDEN NAME Rosa Chiciquina			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no				16. SOCIAL SECURITY NO 213-10-6869				17. INFORMANT Mrs. Albert J. DeBiase			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery sclerosis DUE TO (c)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 9 hr			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). none											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/7 1961 to 6/7 1961 , that (I) (we) last saw the deceased alive on 6/7 1961 , and that death occurred at 3:30 pm from the causes and on the date stated above.											
22a. SIGNATURE Robert V. Campbell				22b. DATE SIGNED 6/9/61							
22c. PHYSICIAN'S NAME (Type) Robert T. V. Campbell				22d. ADDRESS Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE 6/10/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE Clifton S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7313 07302

1. PLACE OF DEATH
a. COUNTY WASHINGTON
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN
c. LENGTH OF STAY IN b. 10 HOURS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND
b. COUNTY WASHINGTON
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BENEVOLE RURAL
d. STREET ADDRESS BOONSBORO MD. R.I.

3. NAME OF DECEASED (Type or print) RENO VERDEEN STOFFER
4. DATE OF DEATH JUNE - 11 - 1961

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAY - 24 - 1883
9. AGE (In years last birthday) 78 yrs. 0 months 13 days 13 hours 13 min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE APPRAISER
10b. KIND OF BUSINESS OR INDUSTRY BENEVOLE WASH. CO MD
11. BIRTHPLACE (County & State, or foreign country) U.S.A
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME ARTHUR M. STOFFER
14. MOTHER'S MAIDEN NAME SARAH JANE FASNACHT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
16. SOCIAL SECURITY NO. 217-10-3069A
17. INFORMANT HARRY NEWCOMER

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Massive hemorrhage from large gastric ulcer
DUE TO (b) > 400
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis - Benign prostatic hypertrophy

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 8, 1958 to June 11, 1961, that (I) (we) last saw the deceased alive on June 11, 1961, and that death occurred at 6:45 PM, from the causes and on the date stated above.

22a. SIGNATURE Edward W. Ditto III
22b. DATE SIGNED 6/13/61
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D.
22d. ADDRESS 217 West Washington St.

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF JUNE-14-1961
23c. NAME OF CEMETERY OR CREMATORY FAHRNEYS CEMETERY INR. MAPLEVILLE WASH. CO MD
23d. LOCATION (City, town or county) (State)

24. FUNERAL DIRECTOR'S SIGNATURE John A. Ball
25a. REC'D BY REGISTRAR DATE JUN 16 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Harris



VS. A15ME
5M 9/60

C7303

1. PLACE OF DEATH a. COUNTY <u>Washington</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>													
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Md. State Hospital</u>		d. STREET ADDRESS <u>220 W. Chapel Street</u>													
3. NAME OF DECEASED (Type or print) <u>Sarah C Swain</u>		4. DATE OF DEATH Month <u>June</u> Day <u>10</u> Year <u>1961</u>													
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 21 1877</u>												
9. AGE (In years last birthday) <u>83</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td><u>7</u></td> <td><u>19</u></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.	<u>7</u>	<u>19</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
IF UNDER 1 YEAR		IF UNDER 24 HRS.													
Months	Days	Hours	Min.												
<u>7</u>	<u>19</u>														
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>													
13. FATHER'S NAME <u>William Showe</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Mc Coy</u>													
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>													
17. INFORMANT <u>Mrs. Autumn L. Kaiss</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Decon. nsation Due to Renal arterio-sclerosis, Severe</u> DUE TO (b) <u>Fracture Of Pelvis (2-5-61)</u> DUE TO (c)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Patient confused climbed over side rails of bed falling to floor.</u>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.) <u>Patient fell from hospital bed.</u>													
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>2-5-</u> <u>1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office b.d.g., etc.) <u>Hospital</u>	20f. (City or town) <u>Hagerstown, Washington, Md.</u>												
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>6-10-61</u>													
EXAMINER'S NAME (Type) <u>Dr. E. C. Ditto, Jr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 12-61</u>													
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>		22d. LOCATION (City, town, or country) (State) <u>Sharpsburg Md.</u>													
23. FUNERAL DIRECTOR <u>Albert L. Lee of Williamsport, Md.</u>		24a. REC'D BY REGISTRAR <u>June 13 '61</u>													
		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>													



may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7315

07304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Williamsport</u>			
c. LENGTH OF STAY IN TB <u>2 wks. 1 D.</u>				d. STREET ADDRESS <u>RED # 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Cor. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>Lucy</u> Middle <u>Willie</u> Last <u>Thomas</u>		4. DATE OF DEATH		Month <u>6</u> Day <u>30</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/31/1886</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Page Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Sylvester A. Furtado</u>		Address <u>118 W. Salisbury St. Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>7. hypercarotid infarction due to</u>							
420.1 DUE TO (b) <u> </u> DUE TO (c) <u> </u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a. m. <u> </u> p. m. <u> </u>		While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<u>6/30/61</u>		<u>6/30/61</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/30/61</u> to <u>6/30/61</u> , that (I) (we) last saw the deceased alive on <u>6/30/61</u> , and that death occurred <u>at 10:00 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>6/30/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard J. Green</u>				22d. ADDRESS <u>Williamsport Md.</u>			
23a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Williamsport, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Green</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>Williamsport Md.</u>				DATE <u>JUL 5 '61</u>			

I

M



7316

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>7 WKS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>STATE HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Chesapeake</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Farmersville</u> d. STREET ADDRESS <u>National Hwy.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgie Frances Wagner</u>		4. DATE OF DEATH Month Day Year <u>June 19, 1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 - 1891</u>
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HARRY WAGNER</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH ALLEN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO	
17. INFORMANT <u>Hospital Records -</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Arteriosclerosis obliterans, legs</u> INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>unknown</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from <u>April 26, 1961</u> to <u>JUNE 19, 1961</u> , that (1) (we) last saw the deceased alive on <u>JUNE 19, 1961</u> , and that death occurred at <u>11:55 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u> M.D.		22b. DATE SIGNED <u>June 20, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>Western Maryland State Hospital Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-22-61</u>	<u>Rose Hill - Cumberland</u>	<u>Cumberland Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry Emma Berzoe</u>		25a. REC'D BY REGISTRAR <u>C. S. Kline</u>	
ADDRESS <u>Cumberland Md.</u>		25b. REGISTRAR'S SIGNATURE <u>C. S. Kline</u>	

8



CERTIFICATE OF DEATH

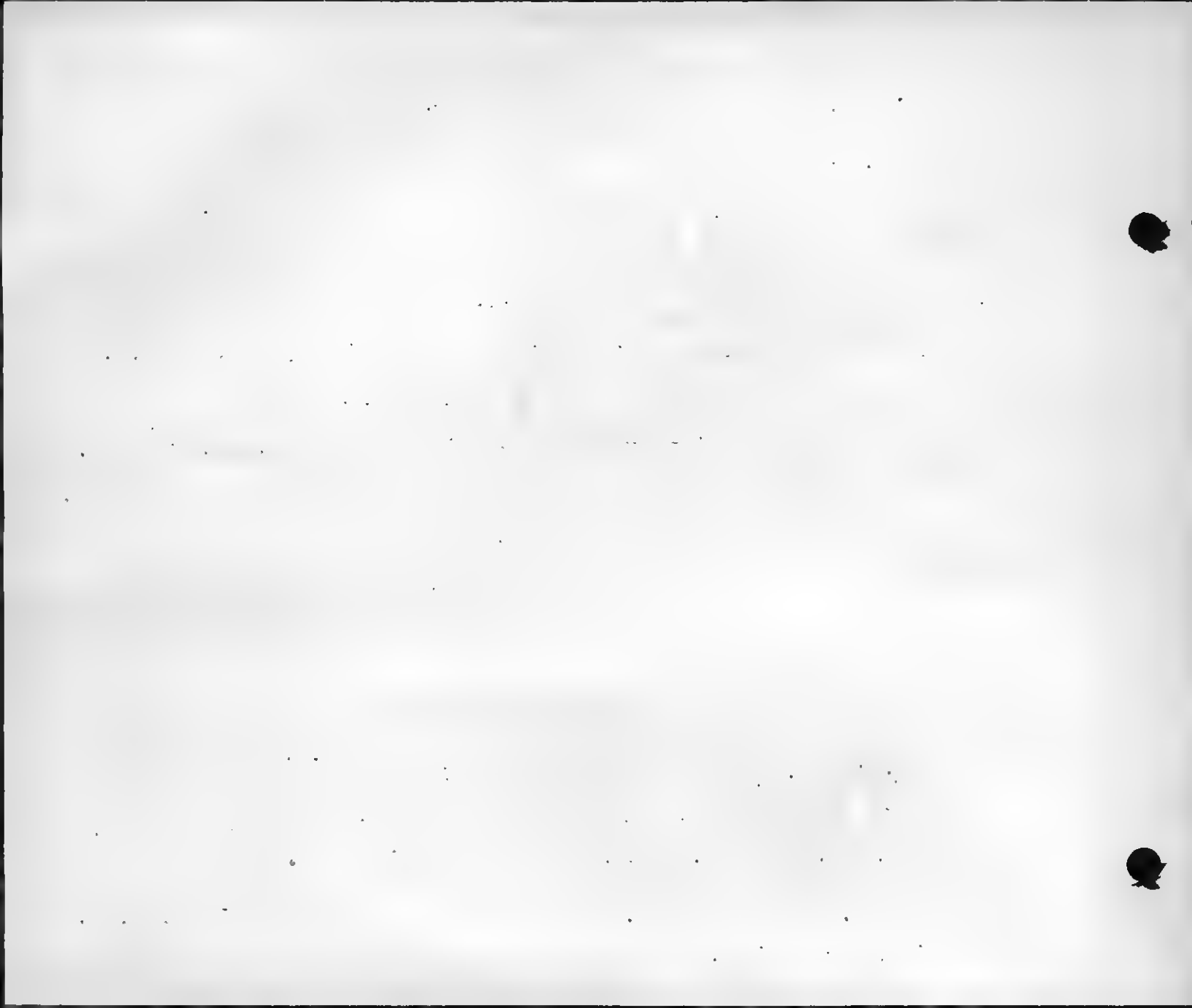
Reg. Dist. No. 07306

7317

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				e. STREET ADDRESS <u>Hamilton Hotel - W.Wash. St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Wesley</u> Last <u>Warrenfeltz</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1883</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day laborer(farm)</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solue Warrenfeltz</u>				14. MOTHER'S MAIDEN NAME <u>Clara Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34-9346</u>		INFORMANT <u>Mrs. Dora Abdullah, 836 Virginia Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephro-sclerosis Arteriolar, right</u> DUE TO (c) <u>Non-functioning left Kidney</u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>1 yr.</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, b. dg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/17/59</u> 19 <u> </u> to <u>June 3rd., 1961</u> , that I last saw the deceased alive on <u>June 3rd., 1961</u> , and that death occurred at <u>2:45 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Maryland</u> DATE SIGNED <u>6/3/61</u>							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>159 W. Washington St., Hagerstown, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 6, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Luth.</u>		22d. LOCATION (City, town or county) (State) <u>Myersville, Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul R. Bittle</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>William L. Knead</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

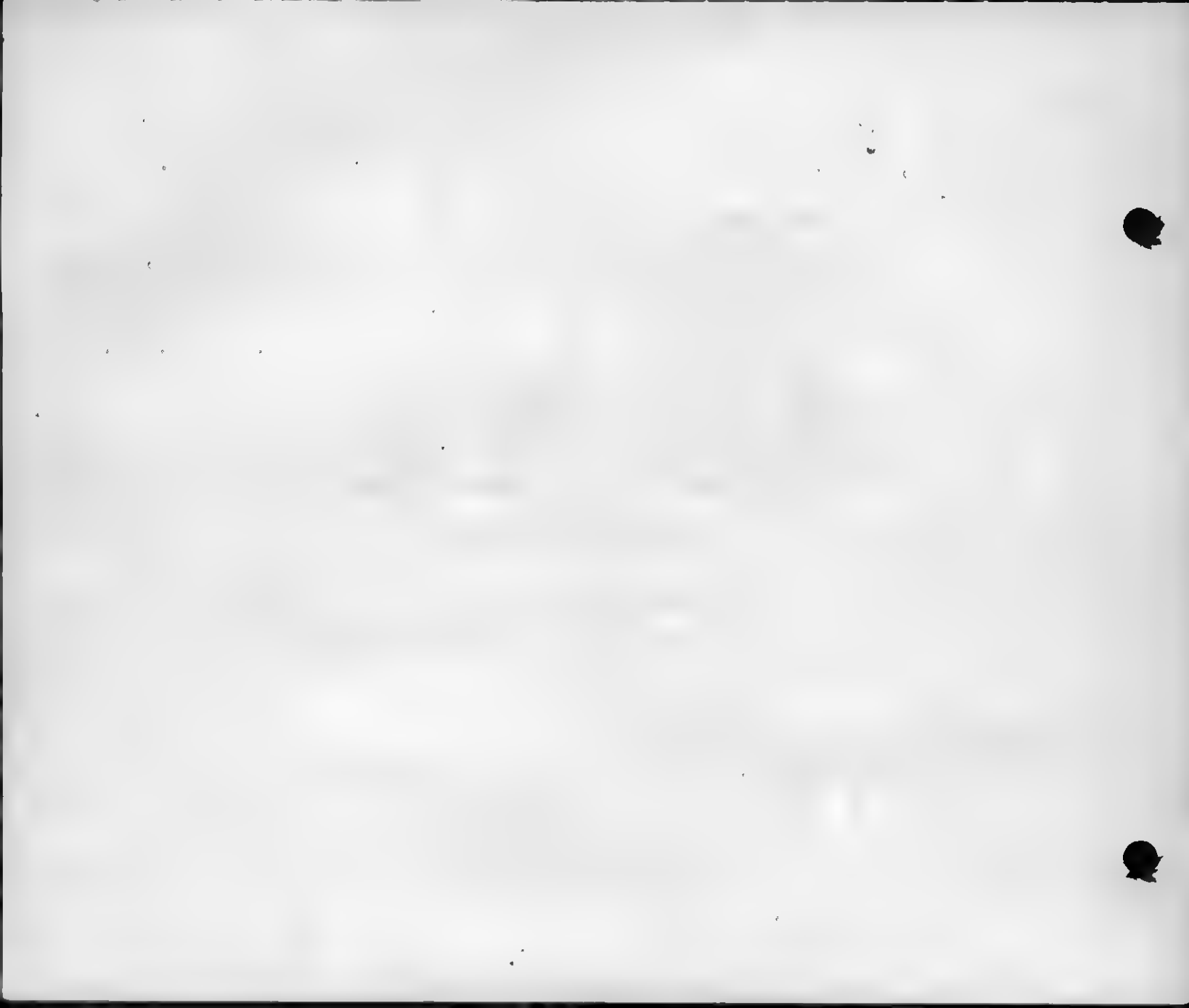


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAY 1961
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07307

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 2, CLEAR SPRING				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 2, CLEAR SPRING, MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESIDENCE				d. STREET ADDRESS NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE ELIZEBETH WEAVER				4. DATE DEATH Month Day Year JUNE 7, 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 20, 1880	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME DUTIES		11. BIRTHPLACE (State or foreign country) WASHINGTON CO., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BERKLEY ROHRER				14. MOTHER'S MAIDEN NAME ELIZEBETH MARTIN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HARRY C. WEAVER RD. 2, CLEAR SPRING, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO CORONARY ARTERY OCCLUSION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 10 minutes unknown							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 7, 1960 to June 7, 1961 , that (I) (we) lost saw the deceased alive on June 6, 1961 , and that death occurred at 1:00 AM , from the causes and on the date stated above.							
22a. SIGNATURE Archie Robert Cohen M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 06/07/61	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				22d. ADDRESS Clear Spring, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 9, 1961		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City, town, or county) (State) CLEAR SPRING, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John F. Clark ADDRESS CLEAR SPRING, MD.				25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	



may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07308

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b _____				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u> d. STREET ADDRESS <u>240 N. Centre St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY</u> <u>EMMA WINTERBERG</u> First Middle Last				4. DATE OF DEATH <u>JUNE 18 1961</u> Month Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Mar. 24, 1895</u> <u>86</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> yrs		9. AGE (In years last birthday) <u>66</u> IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (State or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Richard Hendry</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Reich.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>Mrs Hazel Spittle Balto Md.</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>CARCINOMATOSIS</u> (c) <u>CARCINOMA OF LEFT BREAST</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6-DAYS</u> <u>UNKNOWN</u> <u>20 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21 I certify that (I) (this hospital) attended the deceased from <u>3-15</u> <u>1961</u> , to <u>6-18</u> <u>1961</u> , that (I) was last saw the deceased alive on <u>6-18</u> <u>1961</u> , and that death occurred at <u>7:50</u> <u>PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Antonio U. Pallabrosi</u> 22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLABROSI</u>				22b. DATE SIGNED ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/> 22d. ADDRESS <u>1500 PENNA AVE HAGERSTOWN MD.</u>			
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>		23d. LOCATION (City, town, or county) <u>Cumberland Md.</u> (State) _____	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc - Cumb. Md.</u> ADDRESS _____				25a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles E. Hines</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7320

07309

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 11 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET RUTH YEATES				4. DATE OF DEATH Month Day Year JUNE 5 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1898		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM CLAPSADDLE				14. MOTHER'S MAIDEN NAME LAIRA CRIDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-28-1107		17. INFORMANT MR. CHESTER L. YEATES		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CANCER 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) 9 YRS						INTERVAL BETWEEN ONSET AND DEATH 1 MONTH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 27 , 19 61 , to JUNE 5 , 19 61 , that (I) (we) last saw the deceased alive on JUNE 5 , 19 61 , and that death occurred at 11:35 AM , from the causes and on the date stated above.							
22a. SIGNATURE C. R. Landizabal				22b. DATE SIGNED 6-6-61		22c. PHYSICIAN'S NAME (Type) E. R. Landizabal	
22d. ADDRESS Smithsburg, Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/8/61		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment				25a. REC'D BY REGISTRAR JUN 8 1961		25b. REGISTRAR'S SIGNATURE Arthur L. Huns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07310

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Downsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Downsville</u>			
c. LENGTH OF STAY IN 1b <u>4 years</u>				d. STREET ADDRESS <u>Williamsport RFD #2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woburn Manor Boarding Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Henry Young</u>				4. DATE OF DEATH Month Day Year <u>June 2 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1868</u>	
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Young</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Thomas</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>William T. Young</u> Address <u>1723 Virginia Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intermittent between onset and death</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat white <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>6/2/61</u> to <u>6/2/61</u> , that (I) (we) last saw the deceased alive on <u>6/2/61</u> , and that death occurred at <u>6/3/61</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Ralph Young</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>6/3/61</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Tilghmanton, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thomas</u> ADDRESS <u>Williamsport, Md.</u>				25a. REC'D BY REGISTRAR <u>June 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

(M)

MEMORANDUM

FOR THE DIRECTOR

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